III. THE SMOKING PROBLEM

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3.1 Maine

The smoking problem will be discussed by comparing Maine data with national data whenever possible to provide perspective on the implications of the Maine prevalence rates and other smoking and tobacco use information. The problem will be presented by discussing overall prevalence rates, specific risk groups, use of smokeless tobacco, and finally, costs of tobacco use in the state.

The Maine Bureau of Health has several excellent data sources on the prevalence, mortality, and economic costs of smoking. Prevalence data exists for all age groups. Tobacco-related data is available from the following sources:

1. "Smoking in Maine: A Report on the Health and Economic Consequences of Cigarette Smoking in Maine," 1983, which was derived from the 1980 Maine Baseline Hypertension Household Survey. As one of seven states funded by the National Heart, Lung and Blood Institute for "The Development and Evaluation of a Coordination System for Hypertension Control Activities" a probability sample of households throughout the state was interviewed.

2. The Maine Behavioral Risk Factor Survey and Surveillance System Report - Since December 1986, the Bureau of Health's Division of Health Promotion and Education has participated with the Centers for Disease Control in the implementation of a random-digit dialed telephone survey to determine the prevalence of major behavioral risk factors for premature mortality in Maine.

3. The Maine Youth Tobacco Use Survey, by the Tri-Agency Tobacco Free Project - In 1987, the American Cancer Society, Maine Division Inc.; American Heart Association, Maine Affiliate, Inc. and the American Lung Association of Maine conducted the nation's largest, most comprehensive survey on teen tobacco use. Twenty-eight thousand (28,000) 5^{th}, 7^{th}, 9^{th} and 12^{th} grade students from 72% of public and private schools responded to the survey. This survey was repeated in 1989.

4. Annual Economic Costs and Deaths Attributable to Cigarette Smoking in Maine (1987). A report based on the SAMMEC software package developed by the Minnesota Department of Health. (Schultz 1987).

5. Data from the Women, Infants and Children's (WIC) Program Management Information System.

6. Pregnancy Risk Assessment Monitoring System (PRAMS). The Office of Data, Research and Vital Statistics and the Division of Maternal and Child Health implemented this survey in conjunction with the Centers for Disease Control. It examines risk factors in pregnancies throughout the state.

7. Maine School Smoking Policy Survey - conducted in 1989 by the American Lung Association of Maine identified the extent of nonsmoking policies in Maine school districts.

As a result of these valid data sources, Maine has an excellent foundation for data-based interventions in tobacco prevention and control. In addition, the various health agencies concerned with tobacco in Maine have a history of collaboration. This will be discussed in greater detail, described subsequently.

In addition, national surveys, such as the Current Population Survey (CPS), provide information on Maine.

Smoking prevalence in Maine is 27.9% among persons age 16 and older, with a prevalence of 29.7% among males and 26.3% among females according to the 1985 Current Population Survey (Table III.C.1). More recent figures from the 1987 Maine Behavioral Risk Factor Survey (BRFS) indicate an overall prevalence of 27% for persons age 18 and older, with prevalence among males and females equal to 26% and 27%, respectively. The BRFS data is collected through a random digit dialed telephone survey, whereas the CPS is an in-person survey, therefore, rates may differ due to methodological differences.

Table III.C.1
Smoking Prevalence by Gender
Current Smoking 16 Years of Age and Older
1985

GENDER	PERCENT	TOTAL*
Male	29.7	126.8
Female	26.3	122.8
Total	27.9	249.6

*In Thousands

Sources of Data: Marcus et al., 1989 and Maine Department of Human Services, 1985

To facilitate the comparison of Maine data and national rates, we will refer to data for adults aged 20 and older derived from the 1985 Current Population Survey, reported in Reducing the Health Consequences of Smoking (1989). (Note: required Table III.C.1 shows smoking rates for persons age 16 and older, but use of rates for persons age 20 and older for both the nation and Maine allows direct comparison.) For the nation overall, smoking prevalence was reported as 29.5%, with 32.9% for males and 26.5% for females. Maine smoking prevalence was reported as 30.3% overall, with 31.8% among males and 29.1% among females (USDHHS 1990b and Marcus et al. 1989). According to these data, Maine's overall prevalence rate is slightly higher than the national rate (ranking twenty-fourth among all states). In men the rate is slightly lower, while for women it is quite higher (ranking eighteenth in the country). The most recent smoking prevalence data for the state, the 1987-88 Maine BRFS, showed that prevalence among women has exceeded men for the first time.

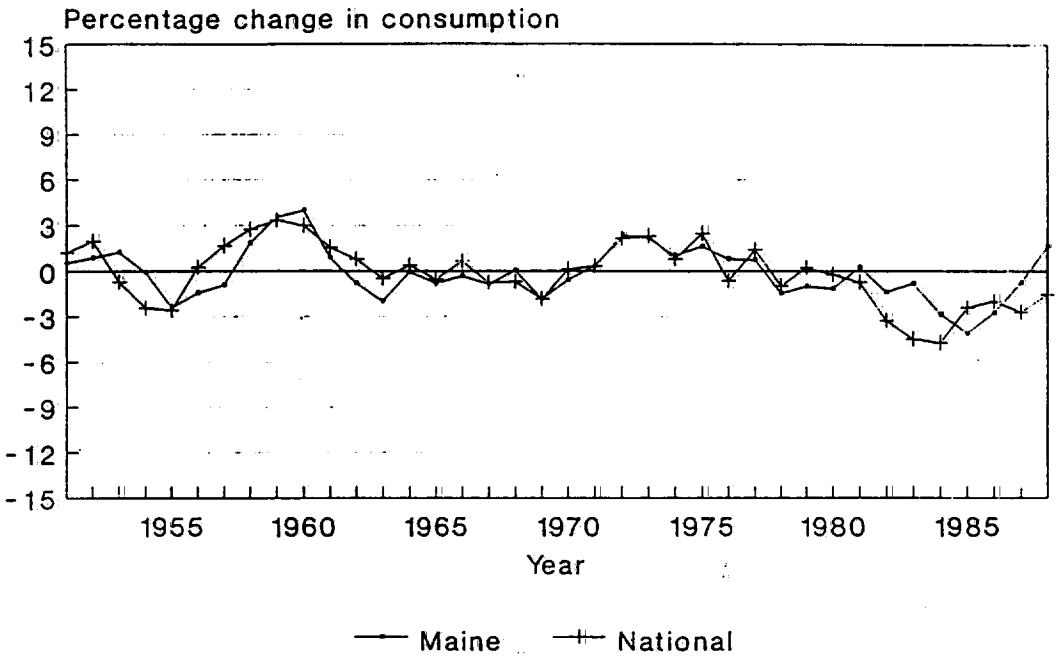
The historical trend for smoking prevalence in Maine can be seen by comparing data from the 1980 Maine Hypertension Control Project Baseline Survey with 1987 BRFS data. Again, comparability is limited by methodological differences. The 1980 Hypertension Survey was a household survey; the BRFS is a telephone survey. The 1980 survey indicated that 37% of males and 33% of females aged 18 years and older were smokers. Comparison with 1987 data shows that over the seven year period smoking prevalence among males has decreased 11% and among females, has decreased 6%.

3.1.1 Cigarette Consumption Data

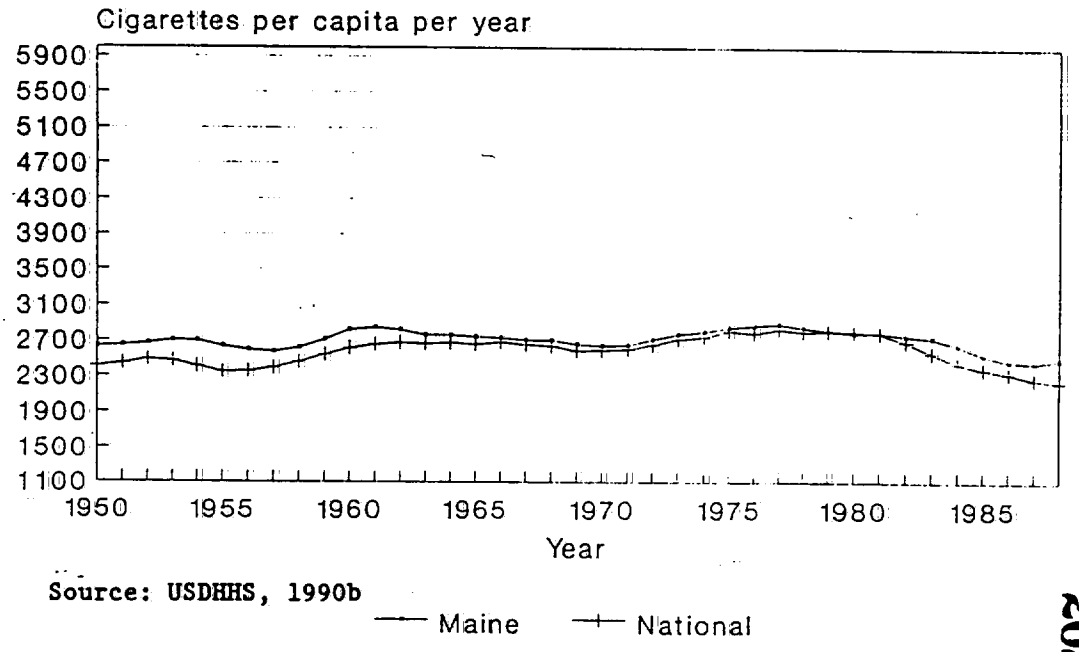
According to data supplied by the U.S. Office on Smoking and Health, Maine's average 1987-1988 per capita cigarette consumption of 2,500 cigarettes per person per year, is higher than the national cigarette consumption (2,252 cigarettes per person per year).

According to BRFS data, the prevalence of current smokers aged 18-34 (32.8%) ranks third in the nation, surpassed only by Tennessee and Kentucky. The proportion of persons aged 18-34 "who ever smoked" (53.1%) ranks first in the nation (Centers for Disease Control 1989).

Annual percentage change in cigarette consumption - Maine



Per capita cigarette consumption Maine



Source: USDHHS, 1990b

3.1.2 Women/Pregnant Women

The number of women smoking is decreasing more slowly than it is for men. The most recent data indicate that smoking prevalence is now higher among women than men in the state (Maine Department of Human Services, 1990b). These are troubling statistics, indicating that, anti-smoking messages are reaching men but not women. Even more troubling is the preponderance of female smokers in the age groups under 45, the prime childbearing years.

Data from the 1988 PRAMS survey indicate that smoking during pregnancy has greatly elevated the number of low birthweight (birthweight of 2,500 grams or less) babies. Of women who bore low birthweight babies, 41.4% reported smoking during pregnancy. In contrast, of women who bore normal birthweight babies, 25.2% reported smoking.

Data from WIC (the federal food supplement program for women, infants and children) eligibility screenings (August, 1987 to December, 1988) indicate smoking prevalence of 41% to 43% in pregnant women. The Director of the Division of Maternal and Child Health indicates this rate may now be as high as 48%. Since Maine has the sixth highest rate of pregnancy among white teens in the nation, one can extrapolate that many of the smoking, pregnant WIC clients are also under the age of 20.

Maine has a significant problem with smoking among women, and especially among pregnant women. This problem is exacerbated by poverty and youth.

3.1.3 Ethnic Minorities

The population, as mentioned in Section I, is primarily white (98.4%). Blacks and Hispanics each represent only 0.3%, while Asians and Native Americans (and others) represent just under 1% of the population. The largest non-white group, according to 1980 Census data, is Native American, numbering 4,087, with 1,430 living on reservations. One reservation is in Penobscot County (Penobscot Tribe) and two are in Washington County (Passamaquoddy Tribes).

The Penobscot Indian Island Reservation has 620 Native American residents. It is a Community Chronic Disease Prevention (CCDP) site, so information on smoking prevalence is available. Over 54% of the residents aged 18 and over smoke, a rate that is double that of the state. The reservation's status as a CCDP site will facilitate participation in the ASSIST program.

Nearly one quarter of Maine residents claim a French ethnic background (Franco-American). French is the primary language spoken in approximately 10% of households. BRFS data (from two PATCH sites

having a substantial French population) show a smoking prevalence similar to the statewide average. However, Franco-Americans are disproportionately represented in such target groups as the lesser educated and blue collar workers.

According to a 1980 survey on Smoking in Maine (Maine Department of Human Services 1983), Franco-American men had a lower prevalence of smoking (34%) as compared to "American only" (38%), while women (identified as French/Canadian/European tended to smoke more often (44%) as compared to "American only" (30%). This group of women was also more likely to be currently smoking than males with similar ethnic identification.

Culturally appropriate strategies and channels will be used to reach both Native Americans and Franco-Americans.

3.1.4 Youth

The Maine Youth Tobacco Use Survey, a joint smoking prevention effort of the American Cancer Society, Maine Division, Inc.; American Heart Association, Maine Affiliate, Inc.; and the American Lung Association of Maine; was designed to obtain current specific data on the prevalence of tobacco use among teens. Twenty-eight thousand fifth, seventh, ninth and twelfth grade students from 72% of all public and private schools responded to the survey in 1987 and 22,174 students responded in 1989.

In 1987, smoking rates for boys and girls were the same, 12.6% of the students responded as current smokers. The smoking rates increase between grades seven and nine from 8.6% to 17.7%. As might be expected, fewer grade five students smoke (3.1%), whereas more grade twelve students smoke (23.2%). Nearly 30% who have tried smoking have quit. Smokeless tobacco use was reported by 7.8% of ninth grade boys, and by 8.3% of twelfth grade boys. Of those who use smokeless tobacco, 45% also smoke cigarettes.

In the 1989 survey 11.2% of students (12.6% in 1987) were smokers. Smoking occured among 2.6% (3.1% in 1987) of 5th graders , 9.7% (8.6% in 1987) of 7th graders, 16.9% (17.7% in 1987) of 9th graders, and 23.1 (23.2% in 1987) of 12th graders. Thus, by the last year of school almost one-quarter of all students were smokers. Since this is only the second survey, no trend analysis is possible. This survey will be repeated every two years to identify trends.

Of the four grades surveyed in 1989, 10.2% of females (12.7% in 1987) and 12.0% of males (12.5% in 1987) reported smoking. Significant differences, however, were found in smoking rates among the 16 counties. Of the current smokers (2.3%) had not yet smoked 100 cigarettes. Seventy-one percent of all students reported being bothered by smoke.

Table III.1
Smoking by Grade and County, 1989

COUNTY	GRADE			
	5	7	9	12
Androscoggin	2.1	11.4	13.7	18.0
Aroostook	2.7	11.3	13.6	24.8
Cumberland	2.5	7.6	23.5	26.1
Franklin	2.3	13.3	15.9	*
Hancock	4.3	6.5	11.7	16.9
Kennebec	2.6	9.0	18.3	22.7
Knox	3.6	12.2	10.2	19.0
Lincoln	2.9	6.5	16.5	23.3
Oxford	3.5	9.3	22.8	26.7
Penobscot	2.2	6.2	15.6	24.3
Piscataquis	1.6	10.0	19.0	*
Sagadahoc	4.2	18.6	21.4	*
Somerset	2.4	15.7	19.9	22.1
Waldo	1.0	2.3	24.6	22.6
Washington	6.1	15.6	19.2	16.3
York	1.4	7.4	15.5	21.9
State	2.6	9.7	16.9	23.1

* *Insufficient Data*

Source: Tri-Agency Tobacco Free Project, 1989

Two and six-tenths percent of the survey population used smokeless tobacco products while 6.0% of 9th grade boys and 8.7% of 12th grade boys used smokeless tobacco at least once a week. As with smoking, the percentage of chew/snuff users was higher in the upper grades. Smokeless tobacco use did not necessarily replace smoking. Forty-seven percent of youngsters who used smokeless tobacco also smoked cigarettes.

Use of smokeless tobacco varied widely among counties. Higher rates were reported for seniors in Franklin, Oxford, and Washington counties. In Somerset County 4.5% of 5th graders reported weekly use as compared to less than 1% reported in four other counties.

A copy of the full summary report of the Tri-Agency Youth Survey is in the Appendix.

Unlike national figures (which show smoking among female high school seniors as higher than that among males) Maine's male high school seniors have a smoking prevalence rate slightly higher than females. This contrasts with the most recent BRFS findings, which show smoking among adult females is higher than that for males.

As found nationally, the overwhelming majority of Maine residents began to smoke when they were teenagers, in the 18-24 age group 96% of the male smokers and 93% of the women smokers. The 1983 Smoking in Maine report indicated that about half of all cigarette smokers in Maine (1980) first acquired the habit during their high school years. Of great concern was the tendency for younger age cohorts to have increasingly large groups who began smoking in the junior high school and primary school years.

Table III.2
Age at Which Smoking Began

MALES

	% Began Before The Age of 12	% Began Age 12-14	% Began Age 15-18	% Began After The Age of 18
18-24	13	28	55	4
25-34	9	13	52	25
35-44	3	15	54	27
45-54	3	20	59	19
55-65	5	19	39	37
65+	6	16	50	27
ALL AGES	6	16	50	27

FEMALES

	% Began Before The Age of 12	% Began Age 12-14	% Began Age 15-18	% Began After The Age of 18
18-24	5	24	64	7
25-34	0	15	54	31
35-44	3	12	62	23
45-54	0	4	60	36
55-65	0	4	40	56
65+	0	8	33	59
ALL AGES	1	11	53	35

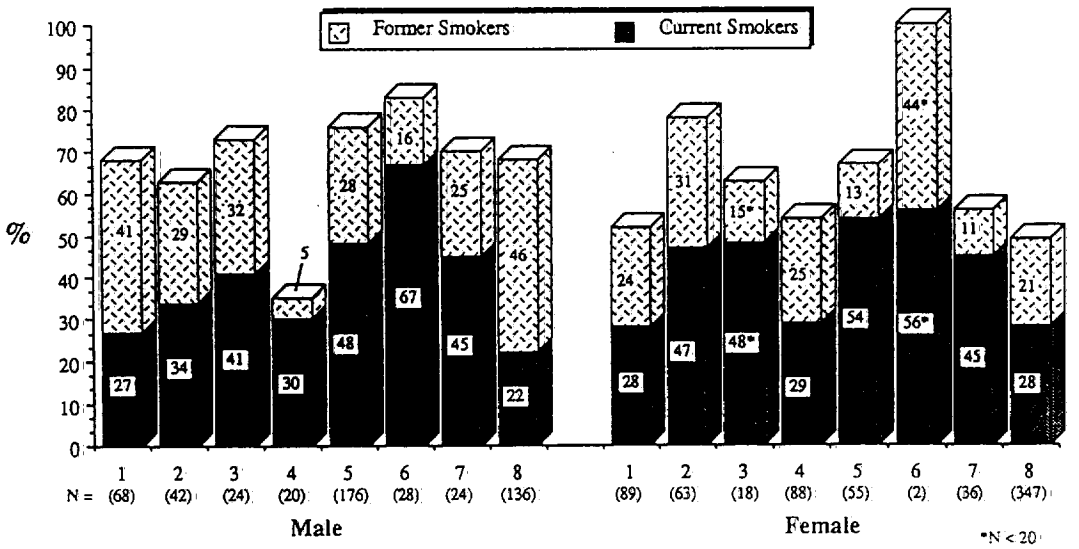
Source: Maine Department of Human Services, 1983

3.1.5 Occupation

The 1983 report, Smoking in Maine, based on data from the 1980 Hypertension Household Survey gives analysis of smoking prevalence data by occupation. Those employed in sales, blue collar jobs, and farming, fishing, and forestry had higher smoking rates than did those in professional and technical jobs. In professional and technical jobs males had smoking rates of 27%, and females 28%. In contrast, in sales, blue collar, and farming, fishing and forestry males had smoking rates from 41-67%, and females from 48-56%. These data are consistent with national trends that show blue collar workers with higher smoking prevalence than white collar workers (see graph below).

The Surgeon General's 25th anniversary report lists national smoking prevalence (based on 1985 data) among white collar workers as 26.4% for males and 28% for females, whereas prevalence among blue collar workers is 40.1% and 33.9%, respectively.

Percentage of Current and Former Smokers by Occupation and Sex



1 = Professional, Technical
2 = Managerial, Administrative, Service
3 = Sales
4 = Clerical
5 = Blue Collar
6 = Farm, Fishing, Forestry
7 = Unemployed
8 = Not in Labor Force

Source: Maine Department of Human Services 1983

3.1.6 Employment Status

Also, consistent with national data, unemployed persons in Maine have higher smoking prevalence rates than those in other employment categories. Most notable is the rate among those who have been unemployed for less than one year (prevalence of 42%), which is 50% higher than the state average (prevalence of 27%).

Table III.3
Estimated Percent at Risk for Smoking by Employment Status

	Estimated Percent at Risk	Approximate 95% Confidence Interval
Employed	30%	27% to 32%
Self Employed	28%	22% to 33%
Unemployed > 1 Year	33%	17% to 50%
Unemployed < 1 Year	42%	28% to 55%
Homemaker	33%	28% to 39%
Student	20%	8% to 33%
Retired	15%	12% to 18%

Source: Maine Department of Human Services, 1990b

3.1.7 Income

Maine residents with low incomes generally tend to smoke more than those with higher incomes. This trend is congruent with higher smoking prevalence among those with less education and among those with blue collar jobs. Smoking prevalence rates by income have remained relatively steady in the past three years, 30% for those with incomes under $20,000, 26% for those with incomes of $20,000 to $35,000, and 22% for those with incomes of $35,000+.

3.1.8 Education

Maine residents with lower levels of education generally smoke more than those who attended more school. This is consistent with data on the inverse relationship between educational attainment and smoking status reported in the 1989 Surgeon General's Report (USDHHS 1989c and Pierce et al. 1990) Maine BRFS data has shown variability within certain educational levels from year to year, especially among four categories: educational attainment of less than 9th grade, some technical school, technical school graduate, and post college education. Some of this variability is due to smaller subsamples in these groups.

Mainers who have graduated from high school or attained lesser levels of education smoke slightly less than their counterparts nationally, and those with college and graduate education smoke slightly more.

Table III.4
Smoking Prevalence (%)

Grade	Maine 1980[1]	Maine 1986[2]	Maine 1987[3]	Maine 1988[3]	U.S. 1987[4]
9th or less	40	35.7	27.7	28	n.a.
Some H.S.	43	33.1	34.5	39	35.7
H.S. grad.	41	32.1	32.0	31	33.1
Some Tech.	n.a.	20.9	18.2	25	n.a.
Tech. Grad.	n.a.	30.1	17.9	16	n.a.
Some College	31	24.8	23.1	23	26.1
College grad.	22	17.7	20.2	18	16.3
Post College	n.a.	10.6	23.8	19	n.a.

Source:
1. Medical Care Development, Inc., 1982
2. Maine Department of Human Services, 1988
3. Maine Department of Human Services, 1990b
4. USDHHS, 1989c

According to Maine BRFS data, the quit rate among male smokers in Maine varies from 29% to 36% for those with a high school education or less, and from 34% to 37% for those with education beyond high school. Among women, there is a striking separation at the cutoff of high school graduation. Female smokers with a high school education or less have quit rates from 14% to 22%, whereas those with education beyond high school have rates from 24% to 29%. Thus, the quit rate among more highly educated Maine women is up to twice that among the less educated (USDHHS 1989c).

In 1988, 3.76% of Maine's 9th through 12th graders dropped out of school. Among all adults in the state (Maine Department of Human Services, 1990b) 18.2% had not graduated from high school. The smoking rate among dropouts under the age of 18 is not being measured by any of the systems currently in place. It is likely to be quite high, if Maine follows national trends.

According to data supplied by the 1985 Current Population Survey the 1985 Quit ratio for Maine smokers, (defined as the proportion of smokers who have "ever smoked" but were "former smokers" at the time of the survey) is in Table III.5.

Table III.5
1985 Quit Ratio (%)

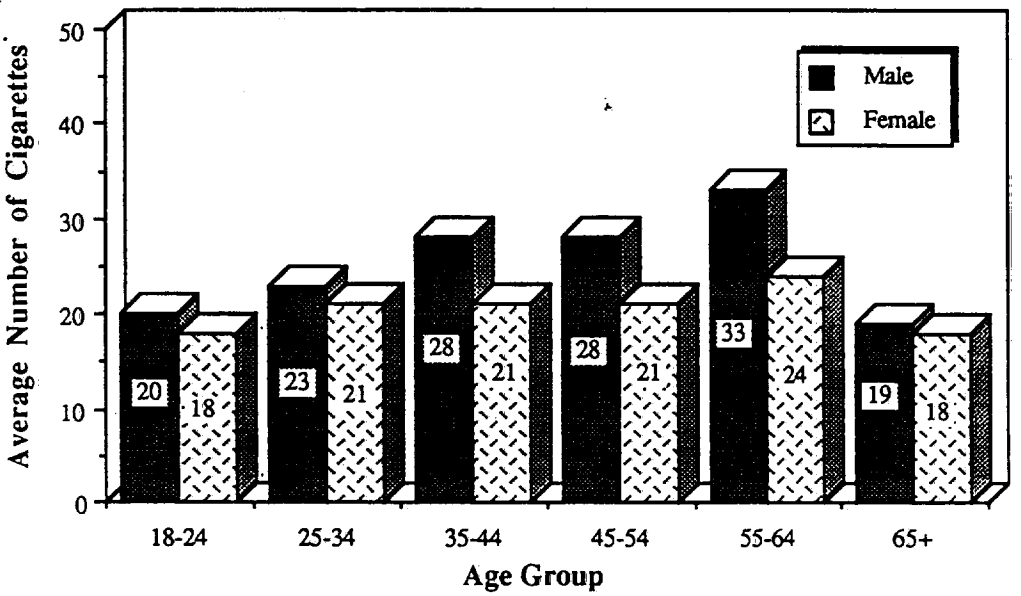
	Maine	U.S.	Maine Rank
Age 20+	45.4	45.0	10
Age group 20-44	36.8		
Age group 45-64	46.3		
Age group 65+	69.0		

Source: USDHHS, 1989c

3.1.9 Heavy Smokers

The heaviest smokers in Maine according data (Maine Department of Human Services 1983) are men aged 55 to 64, who had an average daily consumption of 33 cigarettes. Other age groups of men vary in average consumption from 19 to 28 cigarettes per day. As can be seen in the figure below, the average daily cigarette consumption of women of all ages is lower than that of men. Women's average consumption also varies less by age than does men's. The large drop in daily consumption rates for men ages 55-64 and ages 65+ may be due to earlier mortality and morbidity among the heaviest smokers (e.g., by the age of 65 and older, only lighter smokers still are living).

Average Number of Cigarettes Smoked Per Day By Age Group and Sex



Source: Maine Department of Human Services, 1983

Of current smokers in Maine in 1986, 71% reported smoking less than one pack (20 cigarettes) a day. This was essentially equal to the national rate in 1985 with 73% of smokers reporting smoking 24 or fewer cigarettes per day. The proportion of smokers nationally categorized as "heavy" smokers (25 or more cigarettes per day) did not change significantly from 1974 to 1985. We may assume that the pattern among Maine smokers is similar, although such data are not available.

3.1.10 Smokeless Tobacco

According to 1986 Maine BRFS data, 3.4% of males had ever used or tried smokeless tobacco, as had 0.6% of females. In 1987, 2.7% of males reported current use of smokeless tobacco; in 1988, 1.6% reported such use. The 1987 usage figure is comparable to 1986 data for the northeast region which showed use by 3.0% of males (USDHHS 1989c). It is also comparable to data from the Current Population Survey, (Marcus et al. 1989) which indicate that among males aged 16 years and older, 2.3% use smokeless tobacco, compared to 5.5% in the United States.

Smokeless tobacco use tends to be a much greater problem among young males in Maine. Use in this group was measured by the Maine Youth Tobacco Use Survey in 1987 and 1989, as can be seen in Table III.6.

Table III.6
Smokeless Tobacco use by Grade Level

grade	5	7	9	12
1987	1.1%	2.1%	4.2%	4.6%
1989	1.5%	4.0%	6.0%	8.7%

Source: Tri-Agency Tobacco Free Project, 1989

Smokeless tobacco use among Maine youth has increased over the past two years and is beginning at younger ages.

As mentioned previously, use in the Northeast (as compared to the rest of the nation) tends to be lower, and in Maine the rates for males age 18 and older is comparable with this regional rate. However, use among Maine's high school seniors is nearly 9%, a rate comparable with the nation. One would expect a relatively lower rate among Maine youth to correspond with the lower regional rate. Of great concern is the concurrent use of smokeless tobacco and smoking reported in the Tri-Agency Youth Survey.

High school-aged males in Maine have a significant problem with use of smokeless tobacco. The problem is growing and must be addressed. It is important to note again that the Youth Tobacco Use Survey reaches only young persons who are in school. Dropouts are not included in the figures, and they are likely to be at even greater risk.

3.1.11 Smoking Attributable Mortality, Morbidity and Economic Costs

Costs of smoking can be considered in a number of ways: by looking at mortality, morbidity, years of life lost, and monetary costs of any of these measures.

Smoking-related mortality rates in Maine are shown in Table III.C.2 (p. 75). To put these rates into perspective, Maine rates for 1987 are compared with 1987 national rates for the same ICD-9 codes.

In Maine, 16% of all deaths (1,861 of 12,413 total deaths) in 1985 were attributable to smoking-related illnesses. One hundred and sixty-one out of 100,000 persons died from smoking-related illness. Maine has the sixth highest smoking attributable mortality rate in the nation. The eleventh highest death rate from COPD with 36.6 deaths per 100,000 inhabitants. The eleventh highest coronary heart disease death rate with 257.4 deaths per 100,000.

Maine death rates are slightly lower than national rates in only two subgroups: females with COPD and with stroke. While the rates in four subgroups (COPD, lung cancer, CHD, other cancer) and overall for both sexes are higher than the national rates. Male rates of death from COPD and lung cancer are 7.9/100,000 and 5.7/100,000. The female death rate from CHD and other smoking-related cancers is 6.1/100,000. Overall death rates are 22.1/100,000 among men and 12.2/100,000 among women.

Though these death rates may reflect causes of disease other than smoking behavior, smoking only exacerbates effects of disease precursors in the workplace or home environment. Maine death rates from smoking-related diseases indicate a real need for a strong, comprehensive smoking prevention and control effort.

The Division of Health Promotion and Education has used the Minnesota Department of Health, Center for Nonsmoking software package SAMMEC (Smoking Attributable Morbidity, Mortality, and Economic Costs) to calculate the impact of smoking at the state level, based on the age, gender, smoking prevalence, and disease rate characteristics of Maine.

Table III.C.2

Smoking Related Mortality Rates*
Due to Cancer, Lung, and Heart Disease by Gender
Maine, 1987

Gender	Population	COPD	CHD	Stroke	Lung CA	Other CA	Overall
Male	Maine	50.9	117.0	52.1	81.7	16.0	317.7
	National	43.0	114.0	49.9	76.0	12.7	295.6
Female	Maine	27.0	119.3	75.1	38.1	14.7	274.3
	National	27.9	113.2	75.8	36.6	8.6	262.1

*Number of Deaths per 100,000 persons.

Notes:

- COPD - Chronic Obstructive Pulmonary Disease includes ICD-9 Codes 490 through 496 only.
- CHD - Chronic Heart Disease includes ICD-9 codes 412, 414, and 416 only.
- Stroke includes ICD-9 codes 430 through 438 only.
- Lung Cancer is ICD-9 code 162.
- Other Cancers include lip, tongue, other oral, larynx, pharynx, cervix, and bladder cancers. ICD-9 codes are 140, 141, 142 through 145 and 149.1 through 149.9, 161, 146 through 149.0, 180, and 188 respectively.

Source: Maine Department of Human Services, 1988

This report indicated that overall annual costs of smoking in 1985 equaled $257,424,812. When annual cigarette excise taxes are subtracted, net cost was $224,850,780. These cost figures represent direct health care costs and indirect costs (such as cessation of, or reduction in productivity due to smoking-related disability or death).

We present several detailed tables from the SAMMEC report, which will help to show the scope of the financial and social burden smoking places on Maine's people.

Table III.7 illustrates the costs of smoking for men relative to women, several aspects of which are disproportionate. The disproportionate rates reflect heavier smoking prevalence as well as age of initiation and intensity of smoking.

Table III.7
Costs of Smoking for Men Relative to Women

AGE/GENDER	DIRECT COSTS	INDIRECT MORTALITY	INDIRECT MORBIDITY	TOTAL COSTS
Ages 20+				
Both Sexes	$124,659,230	$86,412,140	$46,353,442	$257,424,812
Male	$69,456,192	$67,115,438	$32,035,455	$168,607,085
Female	$55,203,038	$19,296,702	$14,379,496	$88,879,237
Ages 20-64				
Both Sexes	$74,567,063	$71,469,280	$44,104,686	$190,141,029
Male	$48,051,263	$57,046,177	$30,400,135	$135,497,576
Female	$26,515,800	$14,423,103	$13,899,644	$54,838,547
Ages 65+				
Both Sexes	$50,092,168	$14,942,860	$2,248,755	$67,283,783
Male	$21,404,929	$10,069,260	$1,635,319	$33,109,509
Female	$28,687,238	$4,873,600	$479,852	$34,040,690

Source: Shultz, 1986 and Maine Department of Human Services, 1986

Table III.8 (p. 77) shows the smoking-attributable direct health care costs by five major cost centers. Hospitalization accounts for the greatest overall cost for both males and females.

Table III.8
Smoking-Attributable Direct Health Care Costs, Adults, Ages 20+

DIAGNOSTIC GROUP	MALES	FEMALES	BOTH SEXES AGES 20-64	BOTH SEXES AGES 65+
Hospitalization	$49,961,922	$33,677,269	$62,872,296	$20,766,895
Physician Services	$7,574,265	$3,396,464	$5,092,265	$5,878,465
Nursing Home Care	$8,921,783	$16,508,956	$4,264,347	$21,166,393
Medications	$2,785,612	$1,374,085	$2,238,522	$1,921,144
Professional Svcs.	$212,609	$246,264	$99,603	$359,271
TOTAL PERSONAL HEALTH CARE	$69,456,192	$55,203,038	$74,567,063	$50,092,168
GRAND TOTAL	$124,659,230			

Source: Shultz, 1986 and Maine Department of Human Services, 1986

Table III.9 shows the indirect mortality costs by seven diagnostic disease categories. Premature deaths from lung cancer and ischemic heart disease account for a large proportion of these costs for both sexes at all ages.

Table III.9
Smoking-Attributable Indirect Mortality Costs, Adults, Ages 20+

DIAGNOSTIC GROUP	MALES	FEMALES	BOTH SEXES AGES 20-64	BOTH SEXES AGES 65+
Lung Cancer	$22,858,237	$6,826,462	$25,335,183	$4,349,516
Other Neoplasms	$7,380,251	$2,780,125	$8,639,863	$1,520,513
IHD	$23,748,681	$4,262,007	$25,085,479	$2,925,209
Other Cardiovasc	$4,405,201	$2,641,579	$5,067,150	$1,979,630
Respiratory	$8,170,966	$2,576,321	$6,719,524	$4,027,794
TB	$162,191	$0	$149,757	$12,434
Ulcers	$389,880	$210,208	$472,324	$127,764
COLUMN TOTAL	$67,115,438	$19,296,702	$71,469,280	$14,942,860
GRAND TOTAL	$86,412,140			

Source: Shultz, 1986 and Maine Department of Human Services, 1986

3.2 Portland

The results of the Youth Smoking Survey (Section 3.1.4) done in the Portland Public Schools in 1987 and 1989 can be seen in Table III.1 (p. 66). Smoking data have not been broken down specifically to Portland, residents represent a good sample of the target population, including the largest ethnic populations.

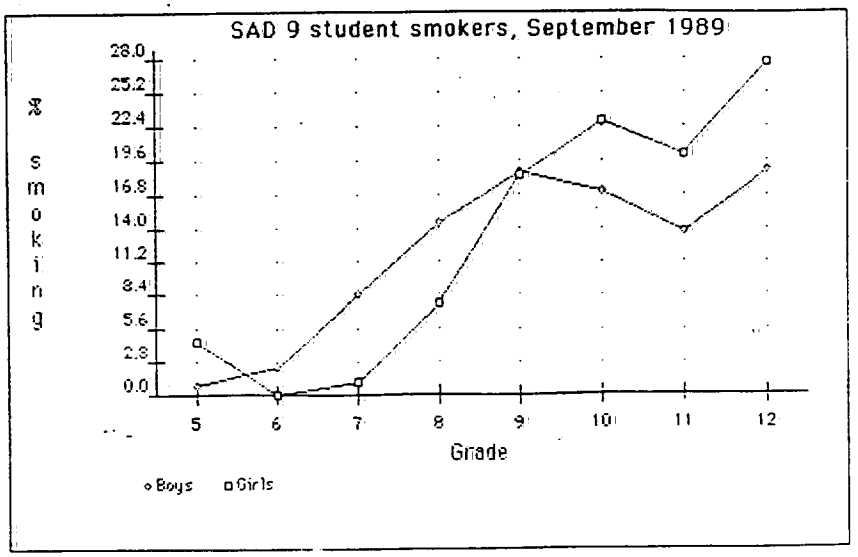
Despite the many strengths this community has through its civic, social and employment networks, there is a paucity of smoking cessation programs. At this time there are two available with limited enrollment and a participation fee.

A BRFS was conducted in one low income neighborhood, and smoking prevalence was found to be 38% among residents over age 35 years. Women smoked at a rate two times higher than men, 64% and 37% respectively. Of the smokers surveyed, 42% had quit for a week within the past year.

3.3 Franklin County Area

Table III.1 (p. 66) lists tobacco use among Franklin County students. Currently, there are no data for the adult population. A local tobacco survey (unpublished) was conducted by the Cooperative Health Education Project in September 1989, for SAD 9 students (Farmington, New Sharon, Wilton, and Weld). Table III.10 lists tobacco use among SAD 9. Similar data will be collected this fall for other school districts.

Table III.10
Smoking Among SAD 9 Students by Sex, 1989



IV. INTERVENTIONS

IV. INTERVENTIONS

4.1 Maine

This section describes the history and status of tobacco prevention and control interventions. The interventions of the state health agency, other state agencies, the major voluntary agencies, and other health-related agencies.

Maine has an active Smoking OR Health community. The state health agency, the Bureau of Health's Division of Health Promotion and Education (DHPE) is the lead unit in state government for tobacco prevention and control planning and interventions. The Office of Dental Health is the unit with major responsibility for smokeless tobacco education.

The DHPE, although serving as the lead unit for tobacco prevention and control, has few or no resources dedicated toward this enormous public health problem. Utilizing existing staff and resources, the DHPE has attempted to overcome the lack of dedicated resources by integrating tobacco issues with other programs. A synergistic approach is taken by utilizing the services and technical assistance of federal agencies, continually promoting attention to the issue through information dissemination, linking with other initiatives, and working with the Coalition on Smoking OR Health (to assist their policy change approaches). The DHPE Director has served as chief staff support for the Governor's Commission on Smoking OR Health in 1989. The Governor's Commission will be described in greater detail in Section 3.1.3.

The DHPE Director is responsible for preparing and presenting the Department of Human Services testimony on tobacco-related legislation in the Maine State Legislature. In addition, the DHPE is responsible for enforcement of provisions of Maine's Workplace Smoking Act of 1985.

The Department of Human Services (DHS) has provided testimony on a number of significant tobacco bills. Legislative bills may be initiated either through an internal process (through Departments or agencies of state government) or may be initiated by individual legislators on their own or at the request of constituents or other interested parties (such as a voluntary health organization, trade association, etc.).

A summary of all tobacco control legislation passed by the Maine State legislature follows, categorized by setting. The US Office on Smoking and Health characterizes Maine "as one of 13 states whose clean indoor air laws rate 'extensive' in restrictiveness. Smoking is restricted in at least four public places, in restaurants, and in private worksites." However, the enforcement of a number of these

laws is a significant problem. A number of laws regulating smoking in indoor air (worksites, restaurants, public buildings, etc.) exist. However, these were passed one at a time, not as part of an overall comprehensive clean indoor air package. The DHS will be submitting legislation to rectify this, thus eliminating the loopholes in the current law. It will be submitted in the next regular legislative session which begins January 1991.

4.1.1 Policy

4.1.1.1 Protection from Involuntary Exposure to ETS

22 M.R.S.A. §1578 Public Meetings: Prohibits smoking at indoor meetings of any public board, commission, agency or authority. Exception: only if all in attendance give their consent for others to smoke. Enacted 1981.

22 M.S.R.A. §1578-A Public Areas: Prohibits smoking in any public area of any publicly owned building. Exceptions: when leased by private groups; indoor restaurants subject to State's restaurant law (22 M.R.S.A. §1579-A); civic auditoriums may provide a smoking area but not in the main entrance area. Enacted 1987.

22 M.R.S.A. §1579-A Restaurants: Restaurants shall provide a no-smoking area to meet the needs of the non-smoking public. Notice of the section will be by sign or verbal announcement. The Department of Human Services shall enforce this law and define the size of the non-smoking area. Violation by a restaurant will result in a fine of not less than $100 nor more than $500. Amended 1989.

22 M.R.S.A. §1580 Jury Rooms: Prohibits smoking in jury rooms. Exceptions: only if all have given their consent to smoke. Enacted 1983.

22 M.R.S.A. §1580-B Ferries: Prohibits smoking in enclosed areas on ferries. Exception: Any area used as a restaurant is governed by the Restaurant Law. Penalties: $100 fine for failure to post a notice; $100 fine for any smoking in a prohibited area. Enacted 1989.

22 M.R.S.A. §1580-B Hospitals: Beginning November 16, 1989, no person may smoke tobacco or any other substance in any enclosed area of any hospital. Exception: A physician may write an order permitting a patient to smoke in a designated area. Enacted 1989.

22 M.R.S.A. §1672-A Shopping Malls: Smoking in common areas of malls is prohibited except in designated areas. Designated smoking areas shall be in locations designed to minimize the effects of environmental tobacco smoke. Smoking in food or beverage service areas is governed by the Restaurant Law. Enacted 1989.

22 M.R.S.A. §1622 Retail Stores: Prohibits smoking in all sections of retail stores over 4,000 square feet open to the public. Enacted 1985.

22 M.R.S.A. §1825 Nursing Homes: Restricts smoking in nursing homes by residents, visitors, and personnel to designated areas. Enacted 1983.

22 M.R.S.A. §1580-A Workplace: Each employer must establish, or may negotiate through the collective bargaining process, a written policy to protect the employer and employees from the detrimental effects of smoking by others. The policy must be posted and supervised by the employer and prohibit smoking except in designated areas. The law does not prohibit employers from establishing policies for members of the public using the facility, nor does it prohibit the employer from banning smoking entirely. Violation: not more than $100. Enforcement authority: Bureau of Health, Department of Human Services. Enacted 1985.

The DHPE conducted a survey of over 900 businesses to determine their reaction to the legislation five months after implementation (in 1986). The specific objectives of the survey were to:

- assess respondent's opinion of the Act
- assess changes in pre-Act policies in businesses
- identify the types of written smoking/non-smoking policies implemented
- evaluate the difficulty or ease of implementation of the Act
- identify businesses still in need of information on policy development/implementation and/or smoking cessation programs

The survey had a 62% response rate; over 581 were returned. An overwhelming majority (85%) of respondents stated they "strongly approve" or "approve" of the Workplace Smoking Act. Seventy-five percent reported "little" or "no difficulty" implementing their policy, while only 3% reported "extreme" difficulty. Almost half (45%) had a smoking/non-smoking policy in effect prior to the passage of the Act. Of those that had a pre-Act policy, 61% made their current policy more restrictive and 39% reported their policy remained the same. Only five percent had no policy or a policy in development. The survey results were reported in Public Health Reports (Maloney 1987).

The DHPE has primary responsibility for enforcement of the Workplace Smoking Act. The provisions of the Act are stated above. The Act was passed by the legislature in 1985, a year before the 1986 Surgeon General's Report on Involuntary Smoking

and the National Academy of Sciences Report on Environmental Tobacco Smoke. Thus, there were significant problems of interpreting and enforcing provisions of the law. This included such terms as "protect the employer and employees from the detrimental effects of smoking by others," "designated smoking area(s)," and "written policy."

Due to the ambiguity and problems in enforcing the law in 1989, the Department of Human Services' utilized the rulemaking process of Maine's Administrative Procedures Act to promulgate rules related to the Workplace Smoking Act. The Department published proposed rules, held a public hearing, and received written comments on the proposed rules from November 1989 through January 1990. Final rules were adopted and published in February 1990.

The rules state that "designated smoking area(s)" must be physically separated from common work areas. They further define "written policy" and define the required contents, use and permissible contents of smoking policies. A copy of the Workplace Smoking Law, Adopted Rules and accompanying materials is provided in the Appendix.

4.1.1.2 Schools, Sales to Minors, Vending Machines

22 M.R.S.A. §1578-B Schools: Prohibits tobacco use by students in school buildings or on school property. Employees and the public are governed by sections 1580-A and 1578-A, respectively. Any designated smoking area for school employees shall be located away from areas frequented by students. Enacted 1988.

22 M.R.S.A. §1579 Sales to Minors: No one may sell, furnish, give away or offer to sell, furnish or give away cigarettes or tobacco to any child under the age of 18. It shall be unlawful for any person under the age of 18 years to purchase cigarettes or any other tobacco product. Amended 1989. Fine: Clerk - not less than $10 nor more than $100, Owner - not less than $100 nor more than $1,000, Minors Purchasing - not less than $10 nor more than $50.

22 M.R.S.A. §1628 Vending Machines: Restricts vending machines sales of cigarettes to locations that are at all times under direct supervision by an adult during the hours the machine is accessible. Amended 1989.

22 M.R.S.A. §2433 Safety: Prohibits smoking in mills, mill yards, passenger buses, shipyards, factories, covered bridges, or stables if notice of no smoking is posted near the principal entrance. Enacted (originally) in 1848.

17-A M.R.S.A. §554 Endangering Welfare of a Child: It is a class D crime (up to 1 year in jail) to furnish or give away tobacco or cigarettes to a child under the age of 16. (Endangering the Welfare of a Child). Enacted 1975.

22 M.R.S.A. §1629 Packaging: No person may sell cigarettes except in the original sealed package which they are placed by the manufacturer. Nor may any person sell cigarettes in smaller quantities than placed by the manufacturer. Fine: Clerk - not less than $10 nor more than $50, Employer - not less than $100 nor more than $1,000. Enacted 1989.

4.1.1.3 Restricting Access to Tobacco by Minors

Several important initiatives aimed at restricting access to tobacco by minors have been initiated over the past few years. These include legislative, advocacy and citizen action initiatives, and public awareness approaches.

4.1.1.3.1 Restriction of Vending Machine Sales

Maine was one of the first states to initiate legislation to restrict sales of tobacco in vending machines. A bill was presented by the Maine Coalition on Smoking OR Health in 1987 to ban vending machine sales of tobacco. After legislative committee hearings, the bill was amended to state that vending machines which sell tobacco must be in "a location that is generally supervised by an adult during the hours the machine is accessible." In 1989 this was amended to state that "it is unlawful for any person, firm or corporation to knowingly distribute or sell cigarettes by the use of a vending machine to minors in a location other than a location that is at all times under direct supervision by an adult during the hours the machine is accessible."

4.1.1.3.2 Restriction of Sales to Minors

Legislation entitled "An Act to Protect Children from Illegal Tobacco Sales" was the major legislative initiative of the Maine Coalition on Smoking OR Health in 1989. The original legislation included provisions regarding licensing of tobacco vendors, permits for tobacco store clerks, and enforcement of sales to minors laws by the Bureau of Alcohol Enforcement. A license fee was proposed, through the administrative court system, which would have funded additional liquor enforcement officers and legal action to rescind licenses. The legislation was assigned to the Committee on Business Regulation whereas tobacco legislation usually is assigned to the Committee on Human Resources which considers health-related legislation. As a result, it was amended in committee and subsequently on the legislative floor. There was strong resistance due to the business regulation aspects. The final version of "An Act to Protect Children form Illegal Tobacco Sales" included the following provisions:

- Sale and distribution; penalty. No person may knowingly sell, furnish, give away of offer to sell, furnish or give away cigarettes or any other tobacco product to any person under the

age of 18 years. No person in the business of selling or otherwise distributing cigarettes or other tobacco products for profit nor an employee or agent of such a person may, in the course of that person's business, distribute free any cigarette or other tobacco product to any person under the age of 18 years in any place, including, but not limited to, a public way or sidewalk, public park or playground, public school or other public building, or an entrance way, lobby, hall or other common area of a private building, shopping center or mall.

- It shall be unlawful for any person under the age of 18 years to purchase cigarettes or any other tobacco product.

- All dealers and distributors of tobacco products shall post notice of this section prohibiting tobacco sales to persons under the age of 18 years. Notices shall be publicly and conspicuously displayed int he dealers' or distributors' places of business in letters at least 3/8 inches high. Signs required by this section must be provided at cost by the Bureau of Liquor Enforcement.

In addition, the following provision regarding the sale of unpackaged cigarettes was included:

- No person may sell cigarettes except in the original, sealed package in which they were placed by the manufacturer nor may any person sell cigarettes in smaller quantities than placed in the package by the manufacturer.

4.1.1.3.3 Smoke-Free Schools

A law passed by the Maine State Legislature in 1987 stated, "no student or school employee is allowed to use tobacco in the buildings or on school grounds of any elementary or secondary school while school is in session." Exceptions cited were:

- Tobacco use my be permitted in classrooms only as part of a bona fide demonstration during a class lesson, with prior notice being given to the school's administrator.

- School employees are prohibited from tobacco use in school buildings or on school grounds, except that a local school board may establish a designated smoking area or areas in accordance with section 1580-A, subsection 3, and employees may reopen collective bargaining negotiations in accordance with section 1578-A, subsection 4, for the purpose of bargaining for smoking areas. Any school employee smoking area shall be located away from areas frequented by students.

A survey of school systems by the American Lung Association of Maine indicated that the number of smoke-free schools (school prohibiting smoking by everyone on school property), more than doubled between 1987 and 1989, from 21 to 54. The survey report stated: "Many schools indicated they used the enactment of the 1987 School Smoking Law, directed primarily at eliminating student smoking, as an opportunity to provide a smoke-free environment for employees, visitors, and others who may be involved with the schools."

Another finding of the survey indicates that 80% (127) of school boards favor more protective no smoking policies regardless of whether or not the school system is currently smoke-free. Only 6% of school boards indicated opposition.

4.1.1.4 Taxation

Excise taxes on cigarettes were increased in 1989 as part of a revenue package to fund a health insurance program for the uninsured. The tax is as follows:

For cigarettes, there was a 9¢ total increase from 28¢ to 37¢ as follows - an additional 3¢ on October 1, 1989, an additional 2¢ on January 1, 1991 and an additional 4¢ on July 1, 1991. For smokeless, from 45% of total sale to 50% on October 1, 1989, 55% on January 1, 1991, and 62% on July 1, 1991. For pipe tobacco and cigars, from 12% to 13% on October 1, 1989, 14% on January 1, 1991 and 17% on July 1, 1991.

4.1.1.5 Health Advocacy by Organizations

4.1.1.5.1 Coalition on Smoking OR Health

The Coalition on Smoking OR Health is composed of over thirty organizational members and close to one hundred total members. Major financial support comes from the three smoking-related voluntary health agencies, American Cancer Society, Maine Division, Inc., American Lung Association of Maine and the American Heart Association, Maine Affiliate, Inc. The Coalition is active in promoting legislative, policy, advocacy and educational interventions on tobacco control. The Coalition has been instrumental in the passage of at least eight pieces of tobacco-related legislation since 1982. A former state health officer served as the Coalition Chair for the first several years. The current chair is Laurie Radovsky, M.D., a family physician. Bureau of Health staff have provided administrative, clerical and logistic support whenever feasible (at times, it is not feasible due to the lobbying efforts of the Coalition).

The Coalition uses most of its budget to hire the services of a lobbying firm in Augusta, MJ Herman Associates. In

addition, several Coalition members, Gordon Smith, Esq., Legal Counsel for the Maine Medical Association and Edward Miller, Executive Director of the American Lung Association are active state house lobbyists for Coalition activities. The Coalition continues to function strongly as a major force in anti-smoking initiatives.

4.1.1.5.2 Governor's Commission on Smoking OR Health

In 1988, representatives of the Coalition on Smoking OR Health, Maine Medical Association, American Lung Association of Maine, and the Cancer Prevention and Control Advisory Committee requested Governor John R. McKernan, Jr. to establish a Governor's Commission on Smoking OR Health. Based on those discussions and in response to an article (Centers for Disease Control 1988) identifying Maine as having the sixth highest smoking attributable mortality rate in the United States, Governor John R. McKernan, Jr. issued an Executive Order (pp. 88 - 90) on January 11, 1989 (the release date of the 25th Anniversary Surgeon General's Report) establishing the Governor's Commission on Smoking OR Health. The Commission was charged with, developing a statewide plan to prevent tobacco use among young people, protect the health of nonsmokers and reduce the health and economic impact of smoking on Maine people. This plan will identify the current status and future direction of:

- Prevention strategies for reaching young people through schools and other youth-serving organizations
- The role of the media in information and education
- Public and private regulatory and policy issues concerning the sale of tobacco, the protection of non-smokers' health, and economic incentives for non-smoking
- Funding for preventive efforts
- Design of a statewide system to assist those smokers who want to quit

The Executive Order specified membership that included "tobacco interests." The largest wholesaler, Pine State Tobacco and Candy Co., the Maine Grocers Association, and the lobbyist for the Tobacco Institute in Maine were named as Commission members. This created an interesting and often difficult situation for Commission members and meetings. A minority report was presented by these three members, much of it written by Tobacco Institute staff.

Executive Order

OFFICE OF
THE GOVERNOR

NO. 3 FY 88-89
DATE January 11, 1989

AN ORDER

CREATING THE GOVERNOR'S

COMMISSION ON SMOKING OR HEALTH

WHEREAS, cigarette smoking is the chief, single preventable cause of death, illness and disability in the United States and in Maine; and

WHEREAS, nearly 2,000 Maine citizens die each year from the consequences of smoking; and

WHEREAS, smoking costs the citizens and taxpayers of Maine an estimated $250,000,000 each year, including

Direct medical costs	$124,659,230
Indirect mortality costs	86,412,140
Indirect morbidity costs	46,353,442
Total	$257,424,812

and,

WHEREAS, over 6,000 Maine children under age 18 begin to smoke each year and 95% of all new smokers become addicted before it is legal for them to purchase cigarettes; and

WHEREAS, a recent survey of over 28,000 students in Maine indicated that about one-fourth of high school seniors are current smokers and that nearly 30% of ninth graders are smokers in some rural counties; and

WHEREAS, a broad-based partnership between the public and private sectors is needed to mount a serious and effective effort to reduce the adverse health and economic consequences caused by cigarette smoking and the use of smokeless tobacco in Maine;

NOW THEREFORE, I, John R. McKernan, Jr., Governor of the State of Maine, do hereby establish the Governor's Commission on Smoking OR Health, the organization and function of which shall be as follows:

Purpose

The Governor's Commission on Smoking or Health is charged with developing a statewide plan to prevent tobacco use among young people, protect the health of non-smokers and reduce the health and economic impact of smoking on Maine people. This plan will identify the current status and future direction of the following:

- Prevention strategies for reaching young people through schools and other youth-serving organizations.
- The role of the media in information and education.
- Public and private regulatory and policy issues concerning the sale of tobacco, the protection of non-smokers health, and economic incentives for non-smoking.
- Funding for prevention efforts.
- Design of a statewide system to assist those smokers who want to quit.

Membership

The Commission shall be comprised of not more than 30 members, to be appointed by the Governor and to serve at his pleasure. The Commission shall include representatives from the following areas:

1. Health education
2. Medicine
3. Public health
4. Law
5. Business
6. Labor
7. Insurance
8. Advertising
9. Education
10. Legislators
11. Parents
12. School administration
13. Students
14. Representatives of tobacco interests

Officers

The Governor shall appoint an Honorary Chair and a Chair to serve during the duration of the Commission.

Administration

The Department of Human Services, the Department of Educational & Cultural Services and the Division of Drug and Alcohol Education shall be responsible for providing staff support to the Commission.

Meetings

The Commission will convene by March 1, 1989 and shall issue its report by January 1, 1990.

Compensation

Members of the Commission shall serve without compensation. Necessary expenditures incurred by members in the performance of their duties which are allowed by State Law shall be borne by their parent organizations.

The effective date of this Order is January 11, 1989.

John R. McKernan, Jr.
Governor

The Commission first met in the Governor's Cabinet Room on January 19, 1989. Three subcommittees were established: Prevention and Youth, Cessation Resources, and Protection of the Non-smokers' Health. The Director of the DHPE served as chief staff. A public health educator from the DHPE staffed one of the subcommittees.

The Commission met at least monthly throughout 1989 reviewing scientific and policy issues regarding smoking or health. Guest speakers and expert consultants made presentations at a number of Commission meetings. A draft report was produced and ready for comments in public hearings in October of 1989. A final report with recommendations was presented to Governor McKernan on February 20, 1989. Lists of the meetings, public hearings, guest speakers, and recommendations follow.

Date of Commission Meeting	Guest Speaker
February 9, 1989	Karen Deasy, Special Assistant to the Director, United States Office on Smoking and Health. A letter from Surgeon General C. Everett Koop was presented to Governor McKernan applauding the formation of the Commission.
March 13, 1989	Jan Hitchcock, PhD, Associate Director, Institute on Smoking Behavior and Policy; Research Associate, Human Services Development Institute, University of Southern Maine. Presentation on Prevention and Youth.
May 8, 1989	Gary Giovinó, PhD, U.S. Office on Smoking and Health; Larry Holcomb, PhD, Consultant to the Tobacco Institute; presentations on Environmental Tobacco Smoke and Involuntary Smoking.
July 20, 1989	Frank Johnson, Director, Bureau of State Employee Health, Department of Administration presentation on smoking cessation activities for State Employees.
August 23, 1989	Diane Parotte, M.D., Occupational Health Physician, Bath Iron Works, presentation on Smoking in the Worksite.
November 14, 1989	Richard Silkman, PhD, Director, State Planning Office, presentation on cigarette excise taxes.

September 15, 1989	Dr. Jacobsen, Medical Director, Augusta Mental Health Institute, discussion on smoking in mental health facilities.
December 22, 1989	Deliberations on final report
February 20, 1990	Presentation of Final Report and Recommendations to Governor McKernan. Meeting held in Governor's Cabinet Room.

Date of Public Hearing	Location
October 18, 1989	Shaw School, Gorham (to review recommendations of the Prevention and Youth Subcommittee)
	Portland City Hall
November 2, 1989	Eastern Maine Medical Center, Bangor
November 14, 1989	State Office Building, Augusta
November 16, 1989	Presque Isle High School (afternoon hearing to review recommendations of the Prevention and Youth Subcommittee); and Presque Isle High School, evening hearing
December 13, 1989	St. Mary's Hospital, Lewiston

The Final Report and Recommendations to Governor McKernan were presented by subcommittee structure. The following is an outline of the report.

I. Prevention and Youth

- A. School Environment
- B. School Curriculum
- C. Sales to Minors

II. Cessation Resources

- A. Smoking Cessation
- B. Worksite Cessation Programs
- C. Selected High Risk Target Groups
- D. Smoking Cessation for the Community

E. Smoking Cessation Training for Health Professionals
F. Comprehensive Program (detailed need for a comprehensive tobacco prevention and control program in the state health agency)

III. Protection of Nonsmoker's Health

A. Creation of a Comprehensive Smoke Free Environment Act
B. Involuntary Smoking and Children: Education
C. Involuntary Smoking and Children: Protection
D. Health Care Facilities

IV. Other Issues

A. Advertising (urge congressional delegation to repeal pre-emption)
B. Excise Taxes
C. Prohibit tobacco "look-alike" products
D. New England Tobacco Free Challenge

A full copy of the final Report is in the Appendix.

4.1.1.5.3 Other Coalitions

As has been previously described, a number of Maine organizations are active in advocacy for health. In addition, many short term coalitions arise for specific issues such as environmental threats, hazardous waste, health insurance coverage, etc.

The Maine Public Health Association has an active and effective legislative network. The Maine Cardiovascular Health Council successfully lobbied for funding for a community-based cardiovascular prevention program in 1989, which includes smoking control programs. Groups such as the Maine Women's Lobby are active in state house lobbying. In 1990 their legislative priority mandated benefits for mammography screening. The American Lung Association of Maine; American Cancer Society, Maine Division, Inc.; and American Heart Association all have active public issues agendas.

4.1.2 Media

Maine has three television markets; the Portland-Poland Spring market reaches 336,000 households (southern and western), the Bangor market serves 116,300 households (central and Eastern), and the Presque Isle market reaches 29,300 households (northern). (A map of these areas is in the appendix.) In addition, there are 93 commercial and public radio stations statewide. Maine Department of Human Services' Office of Public and Legislative Affairs maintains a directory of program directors which will be a resource for campaign planning.

Major newspapers are the Portland Press Herald, Portland Evening Express, the Portland Telegram, Lewiston Daily Sun/Journal (southern and western), the Kennebec Journal and the Waterville Sentinel (central), the Ellsworth American (eastern), and Bangor Daily News (eastern and northern). Local radio stations and community newspapers will be important channels for promotion of Project ASSIST activities as well.

In addition to the traditional means of media, there are a number of other opportunities to reach the target audiences (i.e. house organs, company newsletters, and posters).

4.1.2.1 Division of Health Promotion and Education (DHPE) Activities

DHPE is an active user of Office of Smoking and Health, and National Heart, Lung, and Blood Institute Public Service Announcements (PSAs). DHPE receives the PSAs from the Federal agencies and provides them to all television stations, tagged with the Department of Human Services' logo. Print materials of these agencies are also stocked and distributed.

In 1989, the DHPE worked with the NBC-TV affiliate, WCSH in Portland and WLBZ in Bangor, to produce and promote the NHLBI produced show "Healthy Heart IQ." The Healthy Heart IQ is a one-half hour show on cardiovascular risk reduction focusing on smoking, blood pressure and cholesterol. Fifteen minutes of the half-hour were nationally produced, while the remainder of the show was produced by the local station, which included a quiz on the risk factors. WCSH-TV produced the local segments and scheduled the show to air prime-time (7:30 p.m.) immediately following a "Bill Cosby Show" rerun. The quiz and promotional materials were printed and distributed through a major supermarket chain and through a fast food restaurant.

The DHPE has also worked with the Eastern Maine Medical Center (EMMC) Healthy Heart Program to promote the use of "Smoking Break" a smoking cessation script developed for a TV newscast by WABI-TV, the Bangor CBS affiliate. Smoking Break had been previously utilized in two other states, the script was provided by CDC. The cessation tips aired for one week as part of the newscast.

The DHPE provided assistance to WCSH-TV to produce a series of cessation tips aired by the station around the time of the 1989 Great American Smoke-out. The station's "Healthbeat" reporter, Diane Atwood, appeared in the PSAs. The National Cancer Institute booklet "Clearing the Air," was utilized in the development of the series.

4.1.2.2 Bureau of Health Activities

Media health promotion is regularly utilized by other Divisions in the Bureau of Health. However, as stated above, there is potential for expansion.

The Division of Maternal and Child Health (DMCH) utilizes a variety of media for several of its programs. Posters and print media are distributed to hospitals, clinics, and other health care settings on topics such as child auto safety seats, immunization, nutrition, fetal alcohol syndrome, teen pregnancy prevention, and parenting. DMCH recently developed PSA campaigns on teen driving, teen dating and sexual abstinence. They also produced a magazine on parenting which was distributed in supermarkets throughout the State.

In 1988, the Office on AIDS printed and mailed an informational mailing on AIDS in Maine to every household in the State. The theme of the mailing was, "So You Don't Think There's an AIDS Problem in Maine" with a symbolic message of a stork with its head in the sand.

The Office of Dental Health utilizes print, mass media and live characters for health promotion. A notable character is "Bruce, the Dental Health Moose" who visits schools, shopping malls, fairs, and family festivals, appears on mass media and has made several short feature videos on dental health topics.

The Maine Breast Cancer Control Project is co-sponsoring with the American Cancer Society, Maine Division, Inc., and WCSH-TV, a statewide mammography screening program for the month of October (National Breast Cancer Awareness Month). The program goals are to offer low-cost mammograms to women who have not had one recently, and to increase public and professional awareness of the importance of mammography and proper breast care. The Cancer Information Service will serve as the 800 number during October. A draft telephone script/protocol has been developed. WCSH-TV will feature specials on breast cancer screening including personal interviews, a mammography demonstration and a call-in talk show. The theme of all the television coverage will be the three-pronged approach to screening; breast self-examination, clinical exam, and mammography. In addition, two major newspapers, one in the southern and the other in the northern part of the state, have agreed to do a feature section on breast cancer awareness in late September or early October. This project exemplifies the high degree of collaboration possible in Maine for media and health promotion.

Recently the Breast Cancer Control Project staff were asked by WCSH-TV to respond to the three-part mammography series aired by Tom Brokaw on NBC-TV Evening News. Excerpts from an interview with Dr. Lani Graham, the Project's Principal Investigator and Bureau of Health Director, on the quality of mammography in Maine were aired on the evening news.

The Maine Project LEAN Partners Network has a variety of media and social marketing initiatives planned for the fourth week in October, designated Eat LEAN Week. Radio PSAs are being prepared, posters developed, community and worksite magnet events developed, a Governor's proclamation signed, and a television news feature is being developed.

4.1.3 Program Services

4.1.3.1 Coordination

As previously stated, the DHPE is the lead unit for tobacco prevention and control in state government with other units having secondary roles. The three major voluntary health agencies - American Cancer Society, Maine Division, Inc., American Lung Association of Maine and the American Heart Association, Maine Affiliate all play significant roles in interventions. State agencies involved in prevention and control include:

- The Bureau of Health
  - Division of Health Promotion and Education
  - Office of Dental Health
  - Division of Maternal and Child Health
    - (WIC and prenatal programs)
  - Division of Health Engineering
    - (Indoor Air Quality - ETS)

- Bureau of State Employee Health (Department of Administration) - responsible for health promotion including smoking cessation for state employees

- Office of Alcohol and Drug Abuse Prevention (OADAP)

- Department of Education
  - Division of Curriculum
  - Division of Alcohol and Drug Education Services

To coordinate tobacco prevention and control activities, and maintain a flow of communication, an Interdepartmental Tobacco Coordinating Committee was convened by the DHPE. It is chaired by the Director of the DHPE and meets quarterly.

The DHPE tobacco prevention and control activity is strongly geared toward policy interventions, public awareness and community-based interventions. Cessation resources are in the

domain of the voluntary health agencies and several other organizations such as the Center for Health Promotion in Portland. Program interventions by a variety of sources will be described in this section.

4.1.3.2 Cessation Interventions

There are a number of local and statewide programs for tobacco intervention and control. The American Cancer Society as well as the tri-agency efforts constitute a significant proportion of the programs provided. These activities are described in Section VIII. Programs offered by state and local agencies are described below.

4.1.3.2.1 Division of Health Promotion and Education

The DHPE views its role as a linking agent, bringing developed and tested National programs or intervention research into public health practice on a statewide and community level. The DHPE also stocks and distributes print materials, usually developed by NCI, NHLBI or the U.S. Office on Smoking and Heatlh.

The DHPE, in order to encourage physicians to take a role in smoking cessation, has provided several continuing medical education workshops on minimal clinical interventions for smoking cessation. These workshops were based on "Clinical Opportunities for Smoking Cessation - A Guide for the Busy Physician." They were offered, with the support of the Smoking Education Program of NHLBI, to the Maine Thoracic Society (at their Annual Meeting February 1989), and the medical staff of Eastern Maine Medical Center, (in Bangor, Maine, in conjunction with the EMMC Healthy Heart Program June 1989). Over sixty physicians attended the two workshops.

The DHPE, in conjunction with the NCI's Smoking, Tobacco and Cancer Program, provided a physician train the trainer program on "How to Help Your Patients Stop Smoking: A National Cancer Institute Manual for Physicians" in June 1990. The workshop was co-sponsored by the American Cancer Society - Maine Division, Inc; American Lung Association of Maine; American Heart Association, Maine Affiliate and Maine Coalition on Smoking OR Health. Conference faculty were Marc Manley, M.D. and Rosalind Epps, M.D. of the National Cancer Institute. Thirty practicing physicians attended.

Data from the WIC program show a significantly higher prevalence of smoking among WIC clients than Maine women in general. Since a large number of these women are pregnant and low-income this is an especially high risk group. The DMCH has begun to pilot test the implementation of the American Cancer Society program "Special Delivery" in WIC clinics. Concurrently, an interdivisional team of

staff (from the DMCH, DHPE and the PRAMS Coordinator) have been consulting with CDC's Division of Reproductive Health to determine which elements of the Smoking Cessation in Pregnancy (SCIP) Program may be adapted in WIC and prenatal clinics. This is currently ongoing and will culminate in a prenatal smoking cessation program integrated into the clinics.

The Cardiovascular Risk Reduction Program, recently funded by the Maine State Legislature, specifically includes smoking cessation for communities, public awareness about cardiovascular risks, and training. The program in July 1990 funded seven sites to implement community-based CVD interventions.

The DHPE's Community Health Promotion/Chronic Disease Prevention Unit works with several communities implementing the PATCH (Planned Approach to Community Health) or Community Chronic Disease Prevention Program (CCDPP). Both of these are community-based health behavior risk reduction programs. The CCDP program is directed toward reducing risk of cancer and cardiovascular disease through community interventions. Most of the PATCH and all of the CCDP sites include tobacco prevention and control interventions. The following is a listing of sites and tobacco interventions:

- Mt. Desert Island - cessation groups, promotion of smoke-free restaurants, Great American Smoke-Out tie in
- Portland West Neighborhood Council - smokers anonymous groups, smoke-free policy promotion
- Waterville - smoking prevention resource center
- Penobscot Indian Island - smoke-free policy in the health center/community center, youth prevention, smoking cessation, other PATCH sites are still in developmental stages

4.1.3.2.2 Bureau of State Employee Health

The Bureau of State Employee Health conducts smoking cessation programs for the state employee workforce - the largest workforce in Maine. They could use additional assistance in this activity.

4.1.3.2.3 Eastern Maine Medical Center (EMMC)

The DHPE also works with the Healthy Heart Program of EMMC (Bangor). The Healthy Heart Program is a community-based CVD risk reduction program modeled after the Pawtucket Heart Health Program. The Program has been involved in smoking cessation since 1981. Eight classes are offered each year and in 1989 sixty-three individuals participated in the Stop Smoking Clinic. Other activities include the Smoking Break media intervention (described in Section 4.1.2.1) and an annual Quit and Win program.

The Quit and Win program is an incentive campaign originally developed in the Minnesota Heart Health Program.

> "Quit and Win incentives Campaigns offer a unique approach to helping people in the community or work settings successfully stop smoking. In these campaigns, people pledge to stop smoking for a designated period with the chance to win great prizes and their freedom from smoking. The participants complete an entry form (attached to the promotional brochure) and list names of three contact persons who can verify participants have not smoked during the quit period. At the end of the quit period names are randomly drawn, contacts are called, winners are verified and prizes are awarded" (Maryland Department of Health 1986).

The Program raises prizes and prize money from local businesses. In 1989 over 270 people participated in the Healthy Heart Quit and Win.

The Program utilizes a variety of approaches including lecture, films, guest ex-smokers, informational handouts, group activities and discussion with major emphasis on group involvement, personal skill building and social support.

A Smokers Anonymous group meets at EMMC on a weekly basis. The Healthy Heart Program helped initiate this effort in March 1990. The group is facilitated by "graduates" of the Stop Smoking Clinic.

4.1.3.2.4 Division of Alcohol and Drug Education Services

The Department of Education, Division of Alcohol and Drug Education Services works with over ninety communities in Maine to develop community-school chemical-free teams. Over the past two years, with the technical assistance of the American Lung Association of Maine, nicotine as an addictive drug has been added to their work. Training of community coordinators has been conducted on the integration of tobacco control into their substance abuse plans.

4.1.3.2.5 Osteopathic Hosptial of Maine

The Center for Health Promotion of the Osteopathic Hospital of Maine (Portland) is active in conducting smoking prevention and cessation programs. The Center conducts cessation workshops for community members and for businesses in the Greater Portland Area. The Center was the recipient of a Secretary's Award for Health Promotion in 1986 for a smoking prevention program in Westbrook

Junior High School. The program included development of smoking policies in the school and a cessation program for faculty and students.

The director of the Center, Don Cushing, has also worked closely with the Foundation for Blood Research (FBR) an internationally renowned biological research laboratory on a prenatal cessation program tied to the FBR alpha-fetal protein collection and reporting system. Screening programs, such as the prenatal screening program for open neural tube defects administered by the FBR, can often reach large numbers of providers and individuals. Approximately two-thirds of all pregnant women in Maine participate through their individual physicians. This screening program was used as a vehicle for the delivery of a smoking cessation intervention in a recently completed randomized trial funded by the National Institute for Child Health and Human Development. The pregnant women who reported smoking cigarettes were randomized into either a usual care condition or the experimental condition. The experimental group received, through their physicians, a self-help cessation booklet along with an interpreted laboratory report (on continine levels as assayed from the serum sample already collected as part of the screening program). When implemented as designed, with two physician contacts and continine reports, there was a statistically significant increase in mean birthweight. While this intervention system was discontinued upon completion of the first study, the FBR hopes to soon expand upon the results and implement the intervention with all pregnant women in the screening program who smoke. Funding is currently being sought for this work.

4.1.3.2.6 Coalition on Smoking OR Health

The Coalition on Smoking OR Health initiated a public awareness/citizen action campaign on sales to minors in 1990. The Coalition, through the American Lung Association of Maine, printed a double folded business reply mail postcard to call attention to "observed sale to minors." One half is presented to the storekeeper stating that they have been observed selling cigarettes to a minor and indicating the penalties. The other half is mailed to the American Lung Association of Maine to gather information on the sale in order to build a data base of observed offenses. This initiative is in response to questions raised in the last legislative session regarding the magnitude of the sales to minors problem.

4.1.3.2.7 American Lung Association

The American Lung Association of Maine (ALAM) has developed a statewide delivery system for smoking cessation services. An 80% FTE Health Educator trains facilitators and coordinates cessation services. ALAM has 60 certified Freedom From Smoking Clinic Leaders

providing cessation services statewide in the following locations:

- hospitals (24 out of 39)
- rural health centers
- Indian reservations
- Lifeline - USM
- State of Maine employees (Bureau of State Employee Health)
- Maine Municipal Association
- community health nursing agencies
- private corporations
- schools
- private physicians offices.

At least 35 Freedom From Smoking Clinics have been offered through private corporations or community programs since January 1, 1990. Consultations regarding smoking policy and cessation programs have been offered to G.H. Bass and Company, People's Heritage Bank, the Bureau of State Employee Health and the Maine Municipal Association among others.

The In Control video cessation program has been purchased by at least five major corporations and two vocational technical colleges.

During FY 1989-'90, 2,000 self-help manuals, 500 smoking cessation packets, 15,000 Tips to Quit Smoking and thousands of other smoking cessation materials were distributed statewide at low or no cost.

In December of 1989, thirty chemical health coordinators and school nurses were trained to use the Tobacco-Free Teens program. A follow-up of those trainees and a training for new leaders is planned for late Fall of 1990.

A major statewide television cessation campaign is planned for early 1991.

The ALAM is actively involved in public policy and advocacy to reduce the use of tobacco and protect non-smokers from secondhand smoke, including, but not limited to, the following activities.

- During the 114th Legislative Session testimony was given on nine tobacco related bills.
- ALAM has petitioned a number of Departments of State Government to enact non-smoker protection through the Rules process. This has been a successful method of clarifying or strengthening laws without going back through the legislative process.
- Consultation and assistance is provided to individuals and organizations on protection from the effects from environmental tobacco smoke.

- ALAM maintains a legislative network of over 300 active individuals interested in non-smoker protection. Many of these individuals write or call legislators on smoking related bills.

- ALAM has worked alone and with other organizations to provide education and assistance on smoking related issues. For example, in 1989, ALAM, with the Maine Hospital Association, co-sponsored a workshop to assist Maine hospitals in the implementation of the 1989 Maine Hospital Smoking Law.

The ALAM has worked for years to prevent the onset of tobacco use by Maine children including, but not limited to the following activities.

- Trained approximately 100 health professionals from five regions of the State in the latest classroom methods for preventing young people (grades 4-8) from starting to use tobacco.

- Trained approximately 60 peer helpers from 3 regions of the State to work with younger students on tobacco prevention issues.

- ALAM has a formal relationship with the Division of Alcohol and Drug Education Services of the Department of Education (DADES/DE)regarding the incorporation of nicotine/tobacco into training for their school community teams, drug policies, curriculum, and the DADES Resource Center. All ALAM films/videos on smoking are now housed in the DADES Resource Center. ALAM staff and a number of those trained by ALAM have presented information at drug awareness programs sponsored by DADES and drug prevention teams across the state.

- ALAM staff have been actively working with the Department of Education School Health Consultants on the Healthy Me, Healthy Maine Curriculum Guidelines Project.

- ALAM has been an active partner on the Farmington Cooperative Health Education Committee. The group has chosen smoking as their first target intervention. Staff has provided consultation and training for physicians and other health professionals in the Farmington area and has assisted the group to become established.

- ALAM has adapted the Minnesota Tobacco Use Prevention Curriculum Guidelines for use in Maine. Activities to promote the Guidelines to Maine schools are already underway.

- ALAM maintains an ongoing relationship with Maine schools. This includes providing low-cost materials, consultation, training, referral of classroom speakers and other services.

- Two school smoking policy surveys have been conducted. The first conducted in 1987 was instrumental in the passage of the School Smoking Law that prohibits students smoking and severely limits smoking by staff.

- ALAM has worked cooperatively with the Heart Association and Cancer Society on the Smoke Free Class of 2000 Project.

- Plans are underway with the New England College of Osteopathic Medicine for a project to develop low-literacy, patient education materials on smoking and smoking cessation.

4.1.3.3 Public Education and Resources

Public education for smoking prevention and control may include workshops for policymakers and program for the general public about the smoking issue. The National Cancer Institute states,

> "Environmental tobacco smoke affects the health of the general public and the public must be informed of this risk to protect itself from this hazard. The audience for smoking education, therefore, is the general public. However, resource limitations require that program services for smoking education be carefully aimed toward groups and individuals who can be effective in amplifying or supporting overall smoking prevention and control goals."

General public education programs include the Great American Smoke-out sponsored by the American Cancer Society and Non-Dependence Day sponsored by the American Lung Association. A number of local events are planned each year to coincide with and reinforce these magnet events.

4.1.3.4 Workshops

Workshops on a number of tobacco prevention and control have been conducted by the Bureau of Health, DHPE, the ALAM and others.

The DHPE contracted with the Harvard University Institute for Smoking Behavior and Policy in 1988 for a workshop series. Institute staff provided the following workshops:

- Policy Approaches to Tobacco Control
  Jan Hitchcock, PhD; Nanci Rigotti, MD
  Audience: Health professionals, policymakers

- Achieving the Smoke-free Class of the Year 2000
  John Pinney
  Audience: Coalition on Smoking Or Health

- **Prevention and Youth**
  Jan Hitchcock, PhD
  Audience: School System Substance Abuse Coordinators

Other workshops in Maine have included:

- **Achieving Smoke-free Hospitals (1989)**
  Edward Miller, Executive Director, American Lung Association of Maine; Gordon Smith, Esq., Legal Counsel, Maine Medical Association
  Audience: Hospital Administrators, Sponsored by Maine Hospital Association

- **Smoking Prevention and Control in Maine (1988) at Veterans Administration, Togus, Maine**
  Edward Miller, American Lung Association of Maine; Randy Schwartz, Maine Bureau of Health
  Audience: Health professionals

In addition, as part of the Bureau of Health 1987 Conference on Cancer Prevention and Control (organized by the Cancer Prevention and Control Advisory Committee) included a presentation on tobacco control by Ronald Davis, M.D., Director of the U.S. Office on Smoking and Health.

The DHPE's annual Community Health Promotion Institute (described in detail in Section VII) held for community intervention sites has included a number of tobacco control workshops including:

- Health Communications
  Rose Mary Romano, U.S. Office on Smoking and Health

- Restricting Minor's Access to Tobacco
  Bill Howard, New Brunswick Department of Health

4.2 Portland

4.2.1 Policy

Smoking policy in Portland is no different than for Maine. There are no local ordinances that specifically address smoking. There is a discrepancy in the implementation of the state smoking policy in Portland's public schools. Teachers are provided a smoking room while students are required to go outside.

4.2.2 Media

The capacity of the media network has been previously described (Section 2.5.2). The three national affiliates all have assigned health reporters. The stations are considered approachable for health promotion topics.

4.2.3 Program Services

There are two smoking cessation programs which are offered through a community network and work site channel.

The City of Portland Public Health Division has established a coalition of individuals and organizations to address the reduction of multiple risk factors as they relate to cardiovascular disease. Smoking cessation is one of the key elements that will be addressed.

Coalition membership will include representatives from:

- Portland's Neighborhoods' Association:
  Health Care System -
  - American Cancer Society
  - American Lung Association
  - American Heart Association
  - Hospital
  - Home Health Agency
  - Public Health
  - Family Planning Agency

- Social Services System:
  - Housing Projects
  - Recreation Program
  - P.R.O.P.
  - Refugee Resettlement Program

- Local Government:

- Employees:
  - Employment
  - Unions

- Networks:
  - Portland Public Library
  - Cooperative Extension Services
  - Media

- Schools:
  - Portland Public School Department
  - University of Southern Maine

- Youth Servicing Organizations:
  - Boys and Girls Clubs
  - Campfire Scouts

The coalition structure and function will rely heavily upon the state-wide coalition for guidance in recruitment of members, and development, direction setting and implementation of goals.

The Public Health Division has been serving residents since 1885. It is a multi-faceted municipal public health service organization. The Public Health Division receives financial and human resource services from other organizational units within the City of Portland. A Division organizational chart and an annual report, in the Appendix, more fully describe its experience and capabilities.

4.3 Franklin County Area

4.3.1 Policy

Aside from two local worksites, the hospital and SAD 9, that have smoke free buildings, policies are essentially those of the state. Franklin Memorial Hospital (FMH) also restricts smoking for patients, allowing exceptions only with a physician order). Physician education on the policy and availability of counsellors (for patients agreeing to abstain) have resulted in rare exceptions to the policy.

4.3.2 Media

The local radio station donates a 20 minute per week service slot to the hospital. This is used to interview local physicians and service providers on topics of a medical or social nature. Both local newspapers run weekly health-related syndicated columns, one on general medical problems, the other on family counseling.

4.3.3 Program Services

4.3.3.1 Cessation Resources

The only formal cessation program offered prior to 1989 was the "Breathe Free" program held yearly by a church group. In 1989, three additional channels began offering programs:

School: SAD #9 offered a smoking cessation program attended by 15 and completed by 12 as part of its adult education program.

Medical: FMH began offering meetings with a trained staff member as part of its Hypertension and Cholesterol Reduction Program, as well as weekly support group for abstainers. A medical staff member was trained this year to be a trainer of other physicians in cessation techniques in the office. This training will begin in Fall.

Worksite: Forster Manufacturing offers a program biannually to its employees.

All of these resources will be offered on an ongoing basis and expanded in the future.

4.3.3.2 Prevention Resources

The Cooperative Health Education Project (CHEP) has successfully integrated physicians and nurses into school health teams. These teams represent two of the five school districts served by FMH, and their purpose is to enhance school prevention efforts. Over forty classroom teachers have been paired with medical professionals (including 25 members of the hospital medical staff) to plan and implement curriculum in tobacco use prevention in one school district, and AIDS-related education in the another. Planning for the effort grew out of a collaboration between the hospital, medical staff members, the state Lung Association, the local state university, and one of the school districts. Project coordination was by a physician and the director of the hospital education department. The success of the program (as measured by student, teacher and medical participant evaluations) has led to a goal of further involvement into comprehensive school health education curriculums. Expansion of the project committee to include leaders of clergy and local industry occurred in the spring of 1989, and has led directly to the hospital's workplan for the next year in expanded community prevention services.

4.3.3.1 Public Education Resources

Resources are currently available from the state, state associations and the media.

Locally, CHEP has organized as a health coalition and has begun to address child health, child welfare and tobacco prevention and control. A workplan was developed prior to the decision to integrate the program with the Project ASSIST. A synopsis of the preliminary workplan follows.

The goals of the CHEP program are:

1. Development and implementation of a broad based community coalition through coordinated health promotion and primary prevention efforts.

2. Development of improved measurements of community health and costs of health care to allow:

   - feedback to program planners and the community about the efficacy of efforts,

   - verification of the approach and dissemination of results.

3. Reduction in incidence of preventable targeted health problems (outlined below) and their associated social costs by 50% among a cohort of children currently of preschool age or to be born in the next two years.

Rationale: The hospital realized that the greatest potential for genuine and lasting benefit to the community is in the area of prevention of destructive health behaviors. Significant reductions in the incidence of smoking, alcohol and substance abuse, ill-prepared-for pregnancy and parenting, family violence (including child abuse and neglect) and cardiovascular risk behavior would lead not only to enhanced quality of life (especially for the indigent and working poor who are statistically at highest risk for all of these problems), but also to significant reductions in health care costs.

Strategy: Extensive literature research on successful prevention programs and strategies was carried out over the last year by the CHEP physician chair with hospital administrative support. Literature research was augmented by attendance at key national conferences and consultation with academic and state public health experts. Results were presented to the hospital's trustees and medical staff, and as a result, support was obtained for CHEP.

The strategies to address the health problems are to:

- assess community needs
- prioritize responses to needs
- achieve concensus on community's values and goals
- ensure communication and coordination of services among community institutions and service providers for maximal utilization of existing resources
- promote sharing of specialized services regionally to improve economies of scale
- improve community input to organizations about their programs

- maximize efforts to obtain additional community resources (e.g., grants, startup monies)
- plan, implement and evaluate new prevention programs as needed, at all the community levels

The current 12 Month Workplan will target school districts, the University, health agencies, social agencies (especially DHS), businesses, organized labor, state agencies, local government, church groups, civic groups, law enforcement and interested individuals (especially those being served by programs).

The areas to be addressed are tobacco use, substance use (alcohol and illicit drugs), teen pregnancy, child abuse/neglect, nutrition, cardiovascular risk (blood pressure, cholesterol, inactivity), AIDS, access to health care/coordination of health care, general and specialized (e.g. diabetes health education, and poverty.

A survey of local resources was conducted by a subcommittee from the hospital's family practice service with administrative representatives of existing community organizations to inventory current resources and gaps. Interviews by the physician coordinator with other key community contacts were also conducted. Academic affiliation with the Human Studies Development Institute of the University of Southern Maine and the Bingham Foundation for research support already exists and efforts are being made to increase this involvement.

A committee was formed to plan a major educational and work meeting of all community groups to be involved in the coalition. Outside consultants have been hired to overcome any institutional rivalries. By October 1990, it is anticipated that task forces, reportable to the Coalition, will be formed for each of the targeted risks.

The hospital currently funds one quarter time of the CHEP Physician Coordinator, who reports directly to the hospital CEO. The child abuse and neglect portion of activities have been funded. Grant applications to the federal agencies for tobacco and substance abuse support are pending. Depending on the level of funding, when it starts, and the support of coalition participants, a coordinator will be recruited to provide additional support. Even without further outside funding, activity will proceed as resources and ingenuity allow.

V. MANAGEMENT PLAN

V. MANAGEMENT PLAN

This section describes the proposed plan for managing the Maine Project ASSIST. The management plan will include the following:

- organization and mobilization of the Project ASSIST Coalition to develop and implement a comprehensive smoking prevention and control plan to accelerate the reduction of smoking prevalence.

- establishment of an Office on Smoking OR Health within the Division of Health Promotion and Education (DHPE) of the Bureau of Health to manage and coordinate Project ASSIST. This will provide a highly visible focal point for tobacco prevention and control within the Bureau and in state government, enabling greater institutionalization of all aspects of tobacco prevention and control.

- a subcontract with the Human Services Development Institute of the University of Southern Maine to coordinate the training functions of Project ASSIST. This subcontract will be directed by Jan Hitchcock, PhD, a noted smoking prevention researcher.

- coordination of Project ASSIST activities between the Bureau of Health and American Cancer Society, Maine Division, Inc.

- coordination of Project ASSIST, including coalition member organizations, with the National Cancer Institute ASSIST staff and other Project ASSIST states.

Project ASSIST has been defined by the National Cancer Institute as Phase V Cancer Control Research - the dissemination phase. In the dissemination phase the results of intervention trials are translated through broad application strategies into public health, community practice (Cullen 1986). The state health agency, in conjunction with a voluntary health agency (known for its widespread volunteer network) are in an excellent position to facilitate the dissemination of proven tobacco prevention and control strategies.

A major aspect of public health intervention programs in state health agencies is capacity building of an organizational focus to provide leadership, visibility, coordination, communication and a resource base. Capacity building is defined as

> "the development of the technical expertise to plan, implement and evaluate tobacco prevention and control interventions by the Bureau of Health in a variety of settings throughout Maine. Areas of expertise in

capacity building include: problem identification; epidemiologic and behavioral risk factor analysis; coalition building; program planning; marketing; evaluation, including process, impact and outcome; and the development of capabilities to obtain ongoing support and funding for tobacco prevention and control through administrative and legislative means - beyond the life of this particular grant."

Attention to program institutionalization is an important factor in public health interventions. In implementing Maine Project ASSIST, attention will be paid from the outset to factors necessary for eventual program institutionalization. Recent research (Steckler and Goodman 1989) on institutionalization of health promotion programs will be utilized as the framework in Project ASSIST.

In addition, whereas the ASSIST Coalition plays the central role in the implementation and success of the comprehensive tobacco prevention and control plan in Maine, significant attention will be paid to coalition functioning and maintenance. While organization of a coalition designed to reach the target populations through the intervention channels is important, assuring the effective functioning of all aspects of the Coalition and Project components is critical.

The proposed management plan will address the above issues as well as the required elements: coordination, communication, site analysis, development of a comprehensive smoking control plan, project management plan, training, monitoring, intervention delivery, and administrative activities. The objectives and related activities designed to implement the Project ASSIST management plan are presented below. As has been previously indicated, current tobacco control activities in addition to the Project ASSIST staff will be organized into an Office on Smoking OR Health within the DHPE. The Project ASSIST Manager will be the Director of the Office on Smoking OR Health. Only two other programs in the Bureau of Health have office level designation - the Office on AIDS and the Office of Dental Health. The establishment of the Office on Smoking OR Health will strengthen the organizational focus for tobacco prevention and control. This will greatly improve the capacity to address long and short term tobacco prevention and control issues through the development and implementation of a comprehensive statewide smoking prevention and control plan. ASSIST staff will form the core of the Office on Smoking OR Health and will be responsible for coordinating coalition activities. However, ASSIST activities will maintain the ASSIST name and visibility in all aspects of the workplan.

Upon negotiation of the contract with NCI and notice of award, the Project Director and Project Manager will commence the process of hiring all other Project staff. Upon commencement of Phase II, additional staff will be hired. Staffing patterns will be developed as per the ASSIST Uniform Budget Assumptions.

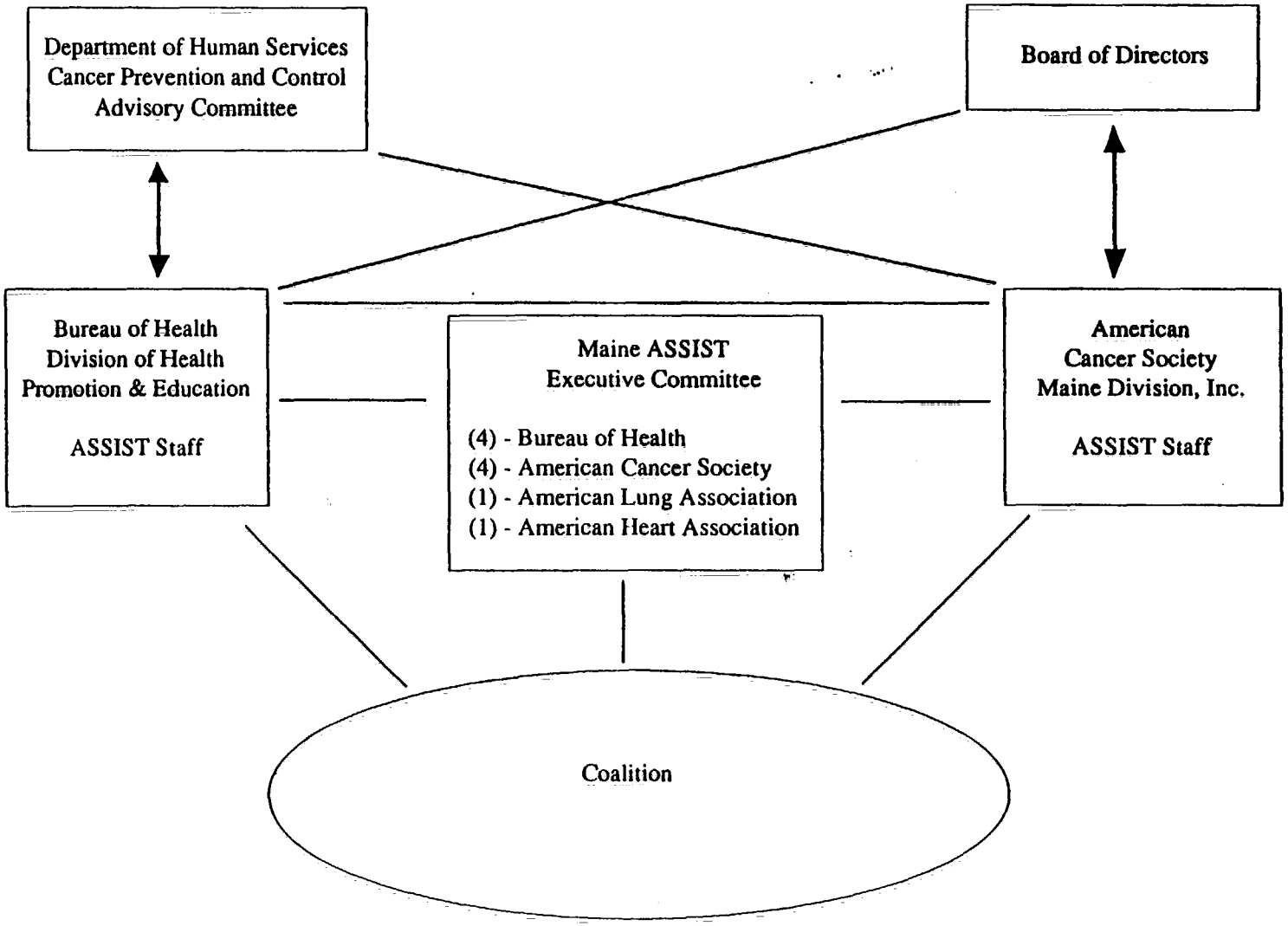
5.1 Project Management

This section describes (a) the organizational relationship between the Maine Bureau of Health/the Bureau's ASSIST staff and the American Cancer Society, Maine Division, Inc./American Cancer Society ASSIST staff and (b) items related to Coalition management.

5.1.1 Bureau of Health - American Cancer Society Relationship

The Bureau of Health and the American Cancer Society, Maine Division, Inc. (ACS) have enjoyed an excellent working relationship on numerous projects over many years. Bureau and ACS staff collaborate as central participants of the Coalition on Smoking OR Health. Both have worked on the Governor's Commission on Smoking OR Health (the former ACS Executive Vice President chaired one of the subcommittees which was staffed by a Public Health Educator from the DHPE), on the Maine School Health Education Coalition, and have co-sponsored workshops together.

The staff of the Maine Breast Cancer Control Project coordinate a number of components of the project with ACS staff. The Director of the DHPE, the proposed Project Director for Maine ASSIST, has served on the ACS Public Issues Committee. ACS President, Dr. Donald Magioncalda, who is chair of the Department of Human Service's Cancer Prevention and Control Advisory Committee, will also serve on the Maine ASSIST Executive Committee. Bureau and ACS staff of the organizations regularly consult informally on a number of issues and programs. Thus, working together on the Maine Project ASSIST will be a collaborative organizational relationship that will be easily coordinated due to years of experience and trust. A chart depicting the ASSIST Bureau of Health and ACS organizational relationship is on the following page.



ASSIST Bureau of Health and American Cancer Society Organizational Relationship

The Coalition structure description in Section VI includes a number of functional subcommittees, technical resource groups, the Advisory Committee and the Executive Committee. The Maine Project ASSIST Executive Committee will be the policy-making body. It will approve all documents developed by the Coalition committees and submitted to NCI, set planning and budget parameters, determine project direction, set program goals, approve overall coalition plans, and supervise implementation of the plans. The Executive Committee will consist of four ACS representatives, four Bureau representatives, the Executive Director of the American Lung Association of Maine and representative of the American Heart Association, Maine Affiliate (AHA). An extensive description of the Executive Committee appears in Section VI.

To assure and maintain communication, a number of operational procedures will be implemented. These include, but may not be limited to:

1. A Memorandum of Understanding will be developed to describe working relationships for ASSIST between the two organizations.

2. A schedule of regular ASSIST staff meetings will be established that will include both Bureau of Health and ACS staff. Meeting locations will include both the ACS offices in Brunswick and the Bureau of Health offices in Augusta.

3. ASSIST staff will attend ACS Board meetings. Reports on ASSIST will be established as a regular agenda item.

4. ASSIST staff will attend Department of Human Services Cancer Prevention and Control Advisory Committee Meetings. Reports, analysis and feedback on ASSIST will be established as a regular agenda item.

5. A regular schedule of ASSIST Executive Committee meetings will be established.

5.1.2 Coalition Management and Maintenance

The Coalition structure is described in detail in Section VI. Each subcommittee and resource group will be staffed by Bureau of Health or ACS staff.

Coalition formation and maintenance entail well thought out approaches that are sensitive to the needs of the constituent groups and that meet the overall project goal. The "Framework for Coalition Research" presented by Goodman (1990) identifies a number of key characteristics and operations of tobacco control coalitions

including: formalized rules, roles and procedures, participation and communication patterns, member recruitment and training, leadership roles, problem-solving processes, resource access and exchange, participatory decision making, community linkages and organizational climate. Those will be addressed in the Maine ASSIST coalition.

The Maine Project ASSIST will develop a number of procedures and activities to assure smooth functioning of the Coalition. These include (but may not be limited to):

1. Maine ASSIST Coalition By-Laws will be developed.

2. Maine Project ASSIST Handbook will be developed.

3. Upon commencement of the Project Phase I, a series of organizational development /coalition building /orientation workshops will be developed and initiated. Workshops such as orientation to ASSIST, group decision making, conflict resolution and others will be implemented as necessary. These workshops will ensure optimal coalition function and process which are critical to the success of the Project.

4. Decision making procedures will be agreed upon.

5. The membership committee will be established to address recruitment and retention issues. For recruitment, there will be an ongoing assessment of the channels for intervention delivery, target populations and interventions to identify needs and gaps. New organizations not previously involved will be presented with a recruitment information package. If necessary, personal calls or visits by staff may be employed. Other recruitment strategies will be developed and employed. Issues related to retention will be addressed through meetings, consultations, training and education, shared agendas, shared rewards and other approaches.

A number of other items discussed in the statement of work, such as those describing communication and coordination, will (explicitly or implicitly) help Coalition functioning.

5.2 Phase I: Project Coordination and Implementation

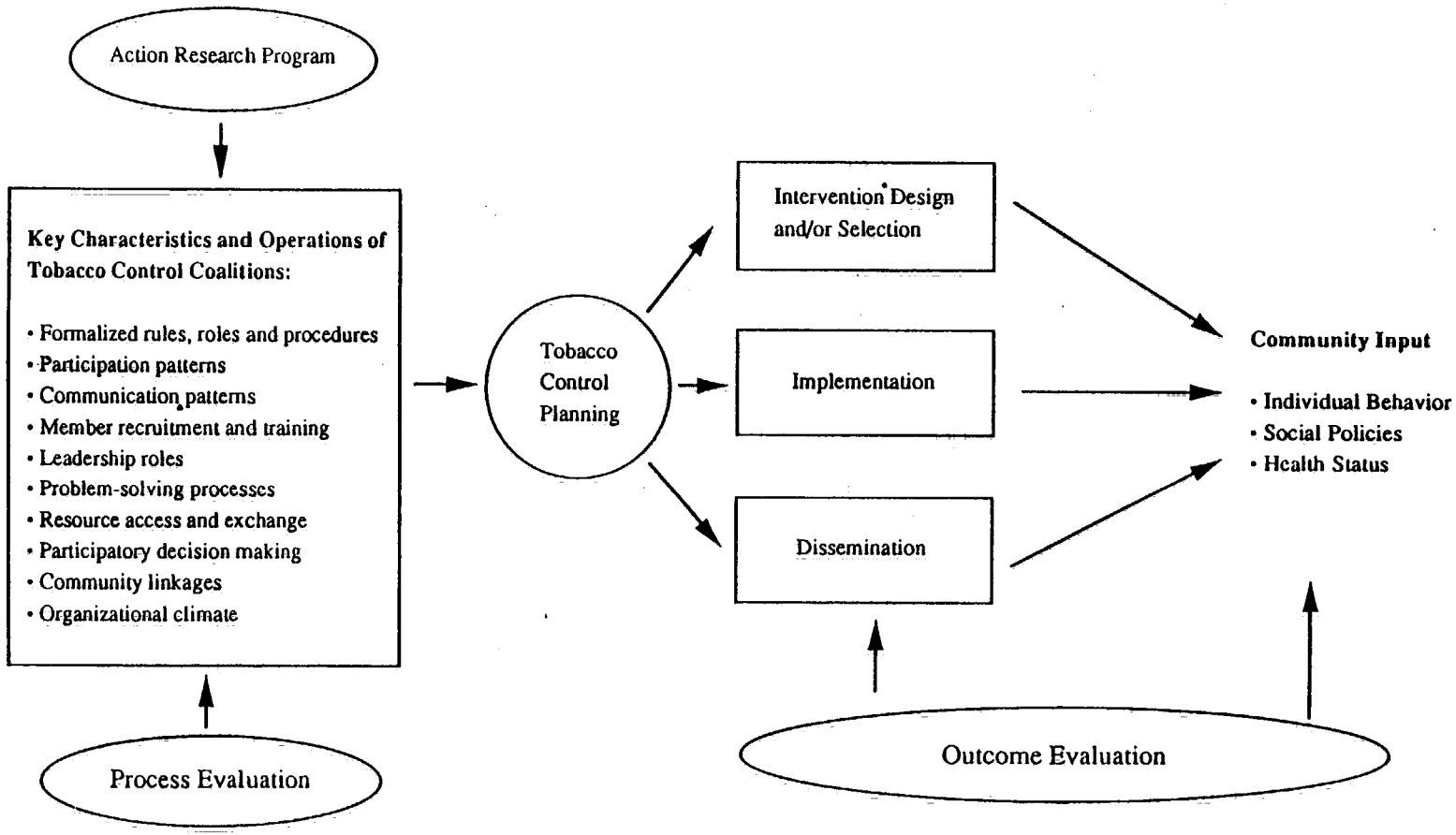
This section describes activities that will be implemented by the Project ASSIST staff including the Bureau of Health and ACS, the Maine ASSIST Coalition and the subcontractor - the University of Southern Maine, Human Services Development Institute (HSDI). A subcontract will be provided to HSDI to coordinate the training needs and logistics of Project ASSIST. ASSIST is based on the tenet that a coalition approach is critical to impact the public health problem of tobacco use. According to the ASSIST description "by its very nature,

a comprehensive smoking prevention and control initiative requires a high degree of planning, support and coordination. A coalition is the organizational structure that allows for diverse organizations to work together for such purposes." A coalition model creates a synergistic effect. The impact of an effective coalition is greater than the sum of its parts.

The Framework for Coalition Research (chart on following page), described by Goodman (1990) identifies key characteristics and operations of tobacco control coalitions. It is necessary to address these key characteristics to ensure functioning of the coalition to achieve the desired community impact and outcome. The Maine Project ASSIST Coalition will address all the characteristics which will be operationalized through Project management, coordination, consultation, training, communication monitoring and the development and operationalization of the comprehensive smoking control plan based on site analysis and plan guidelines.

The Project ASSIST staff will be responsible for site coordination. The purpose of coordination is to try to achieve greater impact by having organizations plan and work together.

FRAMEWORK FOR COALITION RESEARCH



Goodman & Rogers; presented by Robert Goodman at the Society for Public Health Education 1990 Midyear Conference, June 14-16 1990, Portland, Maine

5.2.1 Task 1: Coordination

5.2.1.1 Serve as Liaison Between NCI and Coalition Members

The project staff will be responsible for communicating the requirement of the NCI contract to coalition members, as well as supporting and monitoring the activities of members in order to comply with the terms of the contract. In order to accomplish the task of coordination the following essential activities will occur (to include, but not be limited to):

1. Development of a Project ASSIST orientation manual. The subcontractor, in consultation with Project staff, will develop and deliver an ASSIST orientation training workshop.

2. Development, editing, production and distribution of a Maine Project ASSIST newsletter. It will be published quarterly and include information on NCI contract requirements.

3. Publication of a regular calendar of ASSIST related events

4. Utilization of the University of Maine's Interactive Television System through the subcontractor. The system will be used on a regular basis for meeting and workshop broadcast to ASSIST Coalition members throughout the state.

5. Development of a reporting system to monitor the Project activities of coalition members in conjunction with NCI, the ASSIST Coordinating Center and Coalition members.

5.2.1.2 Provide Leadership and Support for Coalition Meetings

The Maine Project ASSIST staff will provide support for all meetings of the coalition and its various related bodies.

1. Project staff will work with the chairs of the Advisory Committee, subcommittees and technical resource groups (as described in Section VI) to develop an agenda for each meeting. The agenda will include standing items (minutes, announcements, etc.), brief educational items, NCI information and items related to the site analysis and workplan development. Various organizational development experts describe the importance of "agenda integrity." Tropman (1980) suggests that agenda integrity means "(1) all items on the agenda are discussed in the meeting for which they are scheduled and (2) no items not on the agenda are discussed." He further describes several rules for effective meetings: "(1) the rule of halves - get all items to be discussed to the agenda maker half the time between meetings; (2) the rule of thirds - the agenda scheduler orders the items so that the most important items are in the middle third of the agenda; and (3) rule of three-quarters - at the three-quarter point between meetings, all relevant materials are sent to the members."

   While it may be necessary to schedule important items on an emergency basis at times, the notion of agenda integrity is useful for effective meeting planning. These concepts, or a variation thereof, will be adopted in a suggestive, not prescriptive, way. The key point is to keep the meeting agenda germane. Agendas and relevant materials will be mailed by Project ASSIST staff to all committee members at a specific date prior to the meeting.

2. A monitoring and record keeping system will be developed to track the activities of the coalition and all subcommittee meetings.

   Project staff will coordinate all meeting logistics (i.e., reserving the facilities, providing materials, and reimbursing travel and expenses). Standard State of Maine travel reimbursement procedures will be utilized. A statement on travel policy and procedure will be placed in the ASSIST orientation manual. The manual will be produced in a looseleaf binder so that information changes can be incorporated as necessary (such as changes in travel policies).

3. A regular schedule of meetings will be established and distributed. Throughout the Project period meetings will be combined with training sessions to help avoid "meeting burnout."

   a. Project staff will meet biweekly

   b. The Executive Committee will meet bimonthly

   c. The Advisory Committee will meet quarterly

   d. Each subcommittee will meet bimonthly

   e. The full coalition will meet annually

5.2.1.3 Provide Leadership and Support for Local Coalitions

Maine Project ASSIST will provide resources in the form of staff and materials, guidance about the development of local coalition plans, and information about all state level coalition activities to the Portland and Franklin County Area intervention sites. The Project staff will provide logistical support for all local training.

Coordination will be ensured by (but not limited to) the following activities:

1. Project staff will establish a regular site visit schedule and attend meetings in Portland and the Franklin County Area. Staff of the Community sites and local coalition members will participate in the Advisory Committee.

2. The Technical Resource Groups will be available to the community intervention sites to provide technical assistance.

3. The subcontractor, University of Southern Maine, Human Services Development Institute, will work with the community intervention sites to provide training support.

5.2.1.4 Serve as the Central Source of Materials and Resources

The Maine Project ASSIST staff will ensure that coalition member groups are fully informed of NCI training and resources available through ASSIST. Project staff will maintain and promote a readily available record of materials, expertise, and services for use by coalition member groups and local coalitions. This record shall be updated biannually, and its use promoted through each intervention channel.

The Division of Health Promotion and Education currently has at least four vehicles to accomplish this task. They will be modified as necessary to address the needs of Project ASSIST. In addition other resources will be explored and implemented.

The four vehicles include:

1. The Division of Health Promotion and Education's computerized health promotion inventory currently includes a listing of smoking prevention and cessation programs. This section of the inventory will be expanded and promoted in each intervention channel. In addition, Project staff will determine the feasibility of adding an on-line component so that coalition members and others can do an inventory search from an external setting by going on-line to the inventory.

2. The Maine Health Promoter, the Bureau's newsletter (published by the Division of Health Promotion and Education), will include regular updates on Project ASSIST resources.

3. The Department of Human Services Library, a full service health science library, which is organizationally located in the Division of Health Promotion and Education, will serve as a materials clearinghouse for printed and audiovisual smoking prevention and control materials. Procedures for ordering materials will be placed in the ASSIST orientation manual, and will be published in the Maine Health Promoter and the newsletters of all coalition member organizations.

4. The NCI funded Regional Cancer Information Service (CIS) 1-800-4-CANCER number will be used once CIS and ASSIST staff have determined feasibility and means of access.

5.2.1.5 Negotiate Phase II Contract with NCI

The Maine Project ASSIST staff will represent the community intervention sites in all dealings with NCI including the negotiation of contract changes prior to Phase II funding.

1. Pre-negotiation meetings will be set up between the Project staff, the Executive Committee, local community intervention site coordinators, and other representatives. The meeting will review contract requirements, the negotiation process and local site needs.

2. A post-negotiation meeting with local sites will be held with the same participants as above.

5.2.2 Task 2: Communication

5.2.2.1 Coordinate Communication with Coalition Members

Maine Project ASSIST staff will serve as the link among all member groups of the coalition by telephone, mail, electronic mail, and in person. The Subcontractor will, in conjunction with Project staff, provide communication regarding training needs and opportunities. Other information to be communicated by Project staff may include (but not be limited to): meeting information; resources; national, state and local media opportunities; current findings about smoking prevention and control; national events and policy developments. The Maine Project ASSIST staff will simplify technical information to meet the needs of coalition members and the general public.

Communication strategies utilized by Maine Project ASSIST staff will include:

1. Production and distribution of Maine Project ASSIST newsletter.

2. Production and distribution of camera ready articles for newsletters of member organizations.

3. Production and distribution of a directory of all Maine ASSIST Coalition member organizations including organization name, contact person, phone number and fax number.

4. Use of existing electronic bulletin boards -

   - Department of Education bulletin board connecting all school systems
   - Vocational College system bulletin board

5. Utilization of the University's interactive television, (ITV) system (through the subcontract) which links sites throughout the state.

6. Subscription to SCARCNET, the Smoking Control Advocacy Resource Center electronic bulletin board system (DHPE currently subscribes). Action alert items and other SCARCNET postings will be downloaded and distributed as necessary. Information on subscribing to SCARCNET will be provided to all Coalition members as well.

The Data and Technical Information Workgroup will work with all coalition subcommittees, technical resource groups and staff to simplify technical information on smoking prevention and control for use by the Coalition and the public. It is described in greater detail in Section VI.

5.2.2.2 Establish and Maintain ASSIST System of Rapid Communication

The Maine Project ASSIST will implement the system of rapid communication provided by the Coordinating Center.

5.2.2.3 Promote and Utilize National ASSIST Communication Resources

The Maine Project ASSIST will publicize and promote the use of centralized resources available by electronic means. Resources will include: computer bulletin boards, action alerts, events calendar and a video clipping service. All methods of promotion cited above will be utilized.

5.2.3 Task 3: Site Analysis

The Maine Project ASSIST staff will coordinate and work with the Project ASSIST Coalition through its subcommittee structure (as described in Section VI). This is an important aspect of the Project. ASTHO/NCI states, (1989):

> "it is a truism that all politics are local. The smoking problem should always be presented from a state or local perspective." They further state "An effective tobacco use prevention plan includes proposed activities and strategies... with these strategies in mind, a community analysis should be conducted of community resources, including local organizations, state and community leadership, political and power structures, and key decision makers who may implement tobacco use prevention and control strategies and activities."

The Maine Project ASSIST staff and coalition will utilize the NCI "Standards for Comprehensive Smoking Prevention and Control" as the basis for plan development. The Project ASSIST Coalition subcommittees will be charged with developing plans for their respective intervention channels. The Technical Resource Groups will provide technical assistance and consultation to the subcommittees for plan development. The subcommittees will include site analysis and plan development as standing agenda items throughout Phase I. Project staff and associated Bureau staff will provide support for the Site Analysis. Subcommittees will produce and develop the draft by Month 6 of Phase I. It will be reviewed by the Advisory Committee in Month 6, submitted to the Executive Committee after the Advisory Committee review, and approved for final submission by the Executive Committee in Month 8 of Phase I.

The Draft of the Site Analysis will be completed by the Project ASSIST staff and three copies will be sent to NCI by Day 1 of Month 9 in Phase I. The Final Report will be produced by the Project ASSIST staff and three copies submitted to the National Cancer Institute by Day 1 of Month 12 in Phase I.

5.2.4 Task 4: Comprehensive Smoking Control Plan

Based on the site analysis and the NCI Standards for Comprehensive Smoking Prevention and Control, the Maine Project ASSIST staff will coordinate the preparation of a Comprehensive Smoking Control Plan for the State and the two community intervention sites. The Maine Project ASSIST will coordinate coalition members' participation in National training on plan development. In addition, the University of Southern Maine will coordinate any supplemental training needed on plan development or unique aspects of the plan as it relates to Maine. This is described more fully in Task #6, training.

As in the Site Analysis process, each subcommittee will develop the draft workplan for its respective intervention channel. The Technical Resource Groups will integrate the program intervention strategies into the subcommittee plans. In some cases, the Technical Resource Groups may develop plans for specific components of their respective intervention strategy.

The ASTHO/NCI "Guide to Public Health Practice: State Health Agency Tobacco Prevention and Control Plans" will be distributed to all coalition members to guide thinking regarding plan development.

The Maine Project ASSIST Comprehensive Smoking Control Plan will include all items identified in the Statement of Work. These include the following:

1. Overall project mission, goals and objectives.

   This is an important basic step in coalition formation, operation and understanding. ASTHO/NCI states "coalitions frequently begin their work by formulating a short statement of purpose, a mission statement. A mission statement is usually a one to three sentence statement of what the coalition hopes to achieve. Development of a mission statement is a fundamental aspect of the strategic planning process." (Bryson 1988)

2. An introduction to the site and a summary of the site analysis.

This has been initiated as part of the process in responding to the ASSIST Request for Proposals. The Process of completing this aspect of the plan will continue through Phase I.

3. A description and justification of the organization of the site for intervention.

This has been initiated as part of the proposal development. It will continue through Phase I.

4. A description of the complete intervention plan. The intervention plan will include plans to reach all target populations:

- youth
- ethnic minorities
- women
- blue collar workers
- less educated individuals
- smokeless tobacco users

Interventions addressing these target groups will be delivered through all channels:

- worksites
- health care systems
- schools
- community environment
- community networks

via:

- media
- policies
- program services

5. A training plan which includes dissemination of program-specific training provided on the national level by ASSIST.

The subcontractor, HSDI, will coordinate training functions for the Maine Project ASSIST in conjunction with the Project staff, the Executive Committee and Advisory Committee. This will include coordination with national ASSIST training. The subcontract will be described in greater detail in Task 6. In addition, all methods of

communication and coordination previously described will be utilized to disseminate information and training opportunities.

6. Individual statements from participating coalition member organizations describing how project goals will be met through cumulative efforts. This shall include a description of the roles and responsibilities of each member group in conducting Phase II activities and interventions.

This process has begun in response to the RFP and will continue through Phase I. A detailed implementation plan which will include roles and responsibilities including subcommittee and technical resource group assignments will be developed.

7. A Letter of Understanding (LOU) will be developed by Project staff and approved by the Executive Committee. The LOU will detail the responsibilities of the member organization, and the responsibilities of the Maine Project ASSIST staff in consultation and technical assistance.

It is significant that the three major voluntary health agencies in Maine have stated their commitment to Maine Project ASSIST.

8. A plan for statewide activities

The Bureau of Health, the ACS and other major health organizations have experience in coordinating statewide programs. For this activity:

- a detailed planning guide will be developed
- a workshop on statewide events planning will be developed
- pre- and post-event planning meetings will be coordinated

9. A plan for coalition monitoring and oversight of coalition activities.

The Maine Project ASSIST will develop a detailed monitoring and oversight plan. This plan will utilize current process evaluation methods, record keeping and monitoring systems, checklists and self assessment methods, expert panel review and other methodologies. (This is described in greater detail in Task 7, Monitor Phase I activities).

The draft plan will be developed through the Maine ASSIST Coalition structure - subcommittees develop the plan with the assistance of the Technical Resource Groups. The

draft plan will be submitted by the subcommittees to the Advisory Committee by Month 13, Day 1. The Advisory Committee will review and comment on the draft plan, the subcommittees will then revise based on the comments. The Advisory Committee will submit the draft plan to the Executive Committee for approval by Day 1, Month 15. The Executive Committee will approve the draft and submit the draft plan to the NCI Project ASSIST Officer by Day 1 of Month 16.

Based on draft review and comment by NCI staff and Maine ASSIST staff, the final plan will be submitted to the NCI Project ASSIST Officer by Day 1 of Month 21 in Phase I. The approved plan will be widely distributed and promoted throughout the site.

5.2.5 Task 5: Project Management Plan

The Maine Project ASSIST, in consultation with the coalition will develop a management plan for coalition and contract activities.

The Executive Committee will consist of the following representatives: four from Bureau of Health, four from ACS, one from the American Lung Association of Maine and one from the American Heart Association, Maine Affiliate. A description of the Executive Committee is described in Section VI. Various aspects of the management plan will be presented including organizational charts, job descriptions and reporting relationships. The Coalition will develop a set of by-laws and decision making strategies.

The draft management plan will be developed by the Executive Committee and Staff. It will be submitted to the NCI Project Officer by Day One of Month 16, Phase I. Based on comments and revisions, the final draft of the Project Management Plan will be submitted to the NCI Project Officer by Day One of Month 21, Phase I.

Other aspects of the Management Plan described herein will be reviewed, revised and adopted based on local and statewide needs.

5.2.6 Task 6: Training

The Maine Project ASSIST staff, through a subcontract with the HSDI, will coordinate national, statewide and local training opportunities. An important component of ASSIST will be the provision of training for central project staff, those Coalition members involved in project planning, and the providers of direct services. While the NCI ASSIST Coordinating Center will provide resource materials and recommendations for training sessions, each site will need to thoroughly assess its own training needs and opportunities, and develop and implement a system to respond to these needs.

Training needs are anticipated to span a wide variety of areas over the course of the two Phases of the project. These will include group decision making processes, analytic and planning skills, implementation of prevention and cessation programs, institutionalization of non-smoking policies, and mobilization of community involvement in smoking control efforts. In addition to a variety of content areas, a range of channels for such training is likely. These will include on-site workshops across the state, major conferences, the University of Maine's ITV, and written materials.

The HSDI of the University of Southern Maine is proposed as a subcontractor to monitor training needs, coordinate training priorities and resources, and implement training throughout the project. Toward these ends, and reflecting the importance of training functions in the ASSIST project, the subcontractor will work closely with project staff, coalition subcommittees and Technical Resource Groups.

In the planning phase of the project (Years 1 and 2), training will emphasize project management and planning. Project staff and coalition representatives will need orientation to the basic operation and management of ASSIST, including administrative functions; current knowledge of smoking control strategies; principles of mobilization and maintenance of coalition member involvement and community organization; and tools for the site analysis and development of the smoking control plan. In Phase II of the project, training needs will shift to those more directly related to the development of smoking control programs and the implementation of smoking interventions in the field. During both Phases of the project, the subcontractor will be responsible for the monitoring and identification of the training needs, as well as the delivery of training materials and programs. In some cases, HSDI staff will serve as trainers. In the majority of training sessions and workshops, HSDI will identify appropriate resources and speakers within and outside the Coalition, make the arrangement for their participation, and oversee the delivery of this training.

5.2.6.1 Potential Topics for Training

- Orientation to basic operation and management of ASSIST
- Current knowledge of smoking control strategies
- Smoking and current smoking control efforts in Maine
- Principles of mobilization and maintenance of coalition member involvement
- Tools for site analysis
- Group decision making
- Conflict resolution
- Planning and analytic skills
- Components and development of smoking control plan

- Principles of training trainers for health professionals and school personnel
- Principles of community mobilization
- Orientation of resources in smoking control efforts
- Implementation of cessation programs
- Implementation of prevention programs in schools
- Design and implementation of worksite smoking control programs
- Involvement of media in smoking control efforts
- Institutionalization of non-smoking policies in varied settings
- Mobilization of community involvement in smoking control

5.2.6.2 Specific Training Objectives

1. Identify training needs at site:

   - attend subcommittee and Project staff meetings as appropriate
   - set up communication system with project staff and subcommittees to identify training needs
   - establish ongoing monitoring system (via questionnaires), to track training needs
   - integrate NCI suggestions and resources into training

The identification of training needs across Maine and in the intervention sites will entail the integration of input from the NCI Coordinating Center (via project staff), from the subcommittees and the Project Advisory Committee, and from individual Coalition members. To this end, the subcontractor will set up communication systems with Project staff and subcommittees to identify training needs. This will entail attending subcommittee and Project staff meetings as appropriate; establishing and maintaining an ongoing monitoring system, including questionnaires to Coalition members at large, and subgroups; and the integration of NCI and advisory board suggestions and resources into the development of training priorities.

2. Coordinate and prioritize training needs with ASSIST contractual commitments.

Information collected as part of the identification of training needs will be organized according to: priorities established by the ASSIST Coordinating Center, strategic requirements as structured by the planning and implementation functions of Phase I and Phase II, and considerations of the most efficient provision of training relative to specific site needs across and within the state.

3. Identify appropriate resources to meet training needs

- act as liaison with ASSIST staff, subcommittees and technical resource groups, and outside resources, as needed
- coordinate with other site planning functions to identify channels to best deliver training
- identify speakers and trainers, and/or most relevant training materials

In some cases, HSDI staff will be qualified to directly provide the needed training. In most instances, appropriate resources and speakers will be identified through the liaison with ASSIST staff, subcommittees, technical resource groups, and outside resources. Recognizing that choice of training channel may be as important as the particular materials used, the subcontractor will also coordinate with other site planning functions to identify channels through which to best deliver the training.

4. Arrange for delivery of training

- organize and manage on-site workshops in Portland, Augusta, Franklin County Area and other locations in the state: average of one per month during Years 1, 2 and 5-7; a total of 18 per year during Years 3 and 4.
- arrange ITV conferences: 4 ITV conferences a year.
- organize two statewide 1-1/2 days-long conferences (e.g., one during Year 1, and one in Year 3 to kick off Phase II)
- arrange for course credit (e.g., Continuing Education Units, Nursing, Physician) when appropriate.
- videotape all offerings for wider distribution to potential participants who could not attend session.
- produce and/or distribute written training material; contribute to newsletter produced by ASSIST staff.

The subcontractor will organize and manage on-site training workshops in Portland, Augusta, Franklin County and other locations in the state, at a rate, on average of one workshop per month during Years 1, 2 and 5 through 7. During Years 3 and 4, a total of 18 workshops per year will be delivered. During Phase I of the project, the focus will be on site analysis and planning, and the target groups for the training will largely be those directly involved in the organization and management of the Coalitions and subcommittees. During Phase II, especially as the Coalition gains in active membership, the training will broaden to include individuals and organizations more directly involved in the delivery of smoking control activities. Training geared towards those overseeing the planning and management of the project will continue during Phase II, but at a reduced rate.

Four ITV conferences per year will also be organized. The statewide ITV system, administered through the University of Maine, allows simultaneous delivery of material at multiple sites throughout the state when travel to a central location is not possible. In addition, it permits real time interaction between sites, thus offering some possibility of immediate feedback and questioning. ITV conferences are best suited to training events which can be scheduled well in advance, but present, nonetheless, an opportunity for sharing resources and reporting emerging training needs at the time of these conferences.

Two statewide training conferences are planned. One day-and-one-half long conference will be scheduled during Phase I (at Year I), and another during Year 3 to kick off Phase II. Participant expenses to attend these conferences, in particular, overnight accommodations when substantial travel is involved, will be covered by the project.

When appropriate and desirable for the targeted training audience, the subcontractor will arrange for course credit for participation in the training sessions (e.g., Continuing Education Units, continuing education credits for nurses and physicians). All offerings will be videotaped, and made available for wider distribution to potential participants who could not attend a session.

The subcontractor will also produce and/or distribute written training materials, and contribute to a project newsletter produced by ASSIST staff.

5. Monitor delivery of training programs and evolving training needs through close communication with Project staff, and attendance at subcommittee meetings.

Building from communication systems developed as part of the first objective, the subcontractor will maintain close communication with Project staff, continue to attend subcommittee meetings, and maintain contact with the Technical Resource Groups. The initial goal of identifying training needs earlier in the project will be expanded to establish a centralized system for feedback on delivery of training, and on needs for further training. The subcontractor will report on provision of training to central project staff and the Executive Committee quarterly, or as required by the project.

5.2.6.3 Description of the Training Subcontractor

The HSDI is an applied research organization within the University

of Southern Maine's Graduate Program in Public Policy and Management. HSDI is dedicated to improving health and human services through research and program evaluation, policy analysis, technical assistance, and training. Created in 1972, HSDI has conducted research, demonstration and training projects for numerous federal, state and local agencies.

The HSDI has a successful fifteen-year history of collaborative relationships in four major areas: Health Policy, Child Welfare, Aging, and Rehabilitation. The Institute also houses a Research Support Lab which provides computer, survey/market research and quantitative research services.

Client agencies and grantors include the U.S. Department of Health and Human Services, the U.S. Department of Education, the Health Care Financing Administration, Maine Department of Human Services, and the Robert Wood Johnson Foundation, among others.

Jan Hitchcock, PhD, Research Associate with the Human Services Development Institute and Adjunct Associate Professor of Public Policy and Management at the University of Southern Maine, will assume the role of Project Director for this subcontract. Prior to coming to the University of Southern Maine, she was an Associate Director at the Institute for the Study for Smoking Behavior and Policy (ISSBP) at Harvard University. During her six years at ISSBP, she gained exposure to a wide range of smoking control areas and experts (for example, the pharmacology of nicotine to smoking policies). Smoking control among adolescents has been an area of special interest. She has been involved in the planning and delivery of a number of conferences and workshops on smoking control, including a three-day course for staff at the Massachusetts Department of Public Health. She chaired the Prevention subcommittee and drafted prevention recommendations for the Massachusetts smoking control plan in 1987. Since coming to Maine, she served on the Governor's Commission on Smoking OR Health, and is a legislatively appointed member of Maine's Cancer Prevention and Control Advisory Committee.

Polina McDonnell, Research Associate at Human Services Development Institute, who will assume the role of Training Coordinator, has fifteen years of experience in research and technical assistance through HSDI. She has directed numerous research and technical assistance projects in the area of substance abuse, including the evaluation of four community-based model substance abuse prevention projects implemented in Maine under the State's Prevention Initiative. Among her current projects, she is director of a U.S. Department of Education funded project designed to deliver training to substance abuse coordinators in the Maine school systems.

5.2.7 Task 7: Monitor Phase I Activities

5.2.7.1 Collect and Maintain Program Records

As stated, the Maine Project ASSIST will develop a detailed monitoring and oversight plan utilizing current process (or formative) evaluation methods, record keeping and monitoring systems, checklists and self assessment methods, an expert review panel and other methodologies.

Process evaluation has been defined as "an evaluation that provides documentation on what is going on in a program and confirms the existence and availability of physical and structural elements of a program...Process evaluation involves documentation and description of specific program activities - how much of what, for whom, when and by whom." (Windsor et al. 1984)

As stated by Green and Lewis (1986), "formative evaluation after the program is underway should be continuous but is most needed under four conditions:

1. In the initial implementation phases of a recently developed program

2. In the implementation of a refined program in which you have identified 'bugs' or 'rough spots'

3. In the implementation of a previously developed program that you import to a new site

4. In the implementation of a refined health education program that is experiencing new development and variability."

The Project ASSIST meets at least two of the above conditions thus a formative/process evaluation system is appropriate.

Monitoring and record keeping systems are important for program management and process evaluation of health promotion programs (Zapka 1985). Windsor et al (1984) state "As a general rule, health education programs tend to collect too much or too little information on participants. Often the information collected is of such poor quality or so incomplete that it is not useful. Despite the difficulty, a record keeping system is a must for monitoring program implementation."

In conjunction with the Project ASSIST staff and Coordinating Center, the Maine Project ASSIST will develop process evaluation and monitoring systems which will include (at the least, but not necessarily be limited to):

1. Data on intervention participants.

2. Record keeping on all planning meetings.

3. Reporting systems including program activity files.

4. Data on news media reporting of project activities.

5. Data on legislative and policy changes.

6. Media and messages will be evaluated for quality and relevance to target audience; written materials will be evaluated for readability, relevance, etc.

5.2.7.2 Quarterly Reports

Maine Project ASSIST staff will collect information on all project activities for quarterly reports. These reports will include (but not be limited to):

- Items 1-5 above including all program records as specified by the ASSIST Coordinating Center

- Reports on the implementation of the feedback system to provide progress reports to Coalition members (Task 7b, 13a, 13b)

- Report on Task 9d, detailing how Coalition members are informed of training and resources, and the promotion and use of the Project record of program activities, materials, expertise and available services

- Report on item 12a, detailing the identification, recruitment and participation of Coalition members for ASSIST national training, and the dissemination of the skills, strategies, and knowledge presented in the national training (as per ASSIST Coordinating Center).

5.2.7.3 Provide Progress Reports to Coalition Members

The Maine Project ASSIST will plan and implement a system through which each coalition member group receives regular feedback on the extent to which its information gathering and planning activities meet the terms of the NCI contract, as well as on the overall Coalition activities.

A series of procedures will be developed for coalition feedback. These will include but not be limited to:

1. Checklists for self assessment based on the NCI Standards, coalition literature and other sources (Training sessions will be held to provide information on the self assessment process).

2. A series of regularly scheduled regional meetings, site visits and consultation sessions in several regions of the state. (This process bas been successfully utilized by the Maine Diabetes Control Project, which provides technical assistance to 35 patient education programs throughout the state.) Regular agenda items will include the feedback on overall coalition activities, and the member group or relevant subcommittee activity in relation to the overall plan development.

5.2.7.4 Expert Panel Review

To provide consultation to Maine Project ASSIST staff and Coalition members on the implementation and evaluation of the Project ASSIST, including coalition structure and function, development of the comprehensive smoking control plan and other project activities, an Expert Panel Review (EPR) will be convened.

As mentioned previously, a process evaluation should answer the question of who is doing how much of what to whom, by when, and how well (Windsor et al. 1984). An EPR is an efficient way to assess these program dimensions assuming that a written program exists. The EPR may examine selected parts, activities, materials and procedures of program implementation, comparing documentation of the program with a set of standards or professional ratings."

An EPR is useful during planning and early stages of implementation. As recommended by Windsor et al., "a review conducted once in the first six months and again during each year of the project should provide sufficient independent insight into the program's progress." Deeds et al (1979) states, "the review should be a collaborative exercise and should provide practical suggestions for immediate program improvement."

The Maine Project ASSIST will combine the external EPR process with coalition member self assessment record reviews, etc. It will be a participatory, and thus, educational process for staff as well as Coalition members. This process has been used with good results by the Division of Health Promotion and Education in its CDC funded Community Chronic Disease Prevention Program.

The review panel convened for the Maine Project ASSIST will include experts in tobacco prevention and control, coalition building

for public health interventions, and program evaluation and community interventions. Their combined experience will provide excellent feedback to the Maine Project ASSIST. Members will include:

- Michael Eriksen, ScD, Director, Behavioral Research, MD Andersen Cancer Center, University of Texas - expertise in worksite smoking interventions, diffusion of health promotion, cessation, policy interventions.

- Robert Goodman, PhD, MPH, Assistant Professor, University of South Carolina, School of Public Health - expertise in coalition building for health promotion, program evaluation, institutionalization of health promotion programs, community interventions, diffusion of health promotion programs, tobacco prevention and control.

- Thomas Lasater, PhD, Director of the Pawtucket Heart Health Program - expertise in community interventions, use of volunteers in health promotion, smoking prevention.

- Daniel Merrigan, EdD, MPH, Assistant Professor of Public Health, Boston University School of Public Health - expertise in program evaluation, community interventions, worksite interventions, substance abuse.

- Judith Ockene, PhD, Director, Division of Preventive and Behavioral Medicine, University of Massachusetts Medical School - expertise in smoking cessation, training of health care providers in cessation interventions, COMMIT project experience.

- Nancy Rigotti, MD, Internist, former Associate Director of the Harvard University Institute for the Study of Smoking Behavior and Policy - expertise in policy approaches, cessation, senior editorial board for the 25th Surgeon Generals Report.

- Diana Chapman Walsh, PhD, Professor of Public Health, Associate Director, Health Policy Institute, Boston University - expertise in policy approaches to public health, worksite health promotion, tobacco and alcohol policy interventions.

All have agreed to participate. Letters of commitment and CVs are provided in the Appendix.

The Expert Panel will meet once in the first six months of the Project and once every year thereafter. Project staff and the Coalition may further utilize their expertise for occasional off-site review of documents, reports, protocols, etc.

As indicated, Maine Project ASSIST will combine internal review processes with the external review panel process. The Coalition members will participate in the review process. A report on all aspects of the review process will be produced quarterly and distributed to the Coalition.

The Record of Program Activities will be produced by Project staff and reviewed by the Advisory Committee by Day 1 of Month 5, approved by the Executive Committee in Month 5 and submitted to the NCI Project Officer by Day 1 of Month 6. This process will be repeated in each quarter of Phase I and Phase II.

5.2.8 Task 8: Administrative Meetings

The Project Director, Randy Schwartz, MSPH, will attend all coordinating committee meetings. In the event that he is unable to attend, the Project Manager, Sandra Hoover, PhD, MPH or another representative will attend. The Project Director or his representative will attend other administrative meetings as appropriate.

5.3 Phase II: Project Coordination and Implementation

The site analysis, comprehensive smoking prevention and control plan, and management plan will be developed as a result of activities described above in Phase I. The task items for Phase II, will, where they are the same as Phase I, be adjusted and modified based on Phase I experience and formative evaluation. Other task items will be added as described below.

5.3.1 Task 9: Coordination

The Maine Project ASSIST staff and subcontractor will serve as liaison between NCI and Coalition members, provide leadership and support for Coalition meetings, provide leadership and support for local coalitions, and serve as central source of materials and resources. They will accomplish these items based on activities identified in Task 1 and others as necessitated by Phase I experience and formative evaluation.

5.3.2 Task 10: Communication

The Maine Project ASSIST staff and subcontractor will coordinate communication with coalition members, maintain ASSIST system of rapid communication, promote and utilize national ASSIST communication resources. They will accomplish these items based on activities identified in Task 2 and others as necessitated by Phase I experience and formative evaluation.

5.3.3 Task 11: Intervention Delivery

5.3.3.1 NCI Standards for Comprehensive Smoking Prevention and Control

The Project will establish monitoring and quality assurance systems (as stated in Task 7), that will ensure that the activities are performed in accordance with the standards. Interventions will be delivered not only by Project staff but by Coalition members organizations including the American Lung Association of Maine, and the American Heart Association, Maine Affiliate. The intervention plan will detail the respective role of each participating coalition member.

5.3.3.2 Form Working Groups to Oversee Program and Training Needs

The Maine Project ASSIST will form functional subcommittees and technical resource groups to oversee coalition activities, and to identify program and training needs in the various intervention channels. The functional subcommittees will be designed to efficiently and effectively accomplish the Project ASSIST goals. This structure is described in great detail in Section VI. It will be briefly reviewed here.

Four subcommittees will be established - Health Care Systems Subcommittee, Worksite Subcommittee, Educational Systems Subcommittee and Community Networks Subcommittee. The subcommittees will be responsible for developing and drafting the smoking prevention and control plan for their respective channels. The community environment channel will be integrated into all of the other channels.

The following Technical Resource Groups (TRGs) will be developed based on interventions - Media, Program Services, and Policy. In addition, two special resource groups will be developed - Minority and Multicultural and Data and Technical Information. The TRGs will work with each subcommittee to integrate their intervention areas of interest into each specific subcommittee workplan. It is the role of the Minority and Multicultural TRG to ensure that culturally appropriate interventions are developed in all channels. The Data and Technical Information TRG will be responsible for translating national, regional and local smoking data, and epidemiologic and research studies into information that is understandable and meaningful to all subcommittees, the Coalition and the public.

The subcontractor, HSDI, will work with each working group - subcommittees and technical resource groups to identify training needs. This is described in detail in Sections 5.26 and 5.3.4.

5.3.3.3 Modify Phase II Plan as Appropriate

As necessary and appropriate, Maine Project ASSIST will convene the Coalition to modify the Phase II plan to incorporate new scientific findings, to take advantage of unforeseen opportunities for smoking control, and to adapt to changes within the site. All changes will be reviewed by the Advisory Committee, approved by the Executive Committee and submitted to the NCI Project Officer for approval.

5.3.3.4 Issue Annual Coalition Action Plan

Maine Project ASSIST staff in conjunction with all working groups of the subcommittee will develop an Annual Action Plan. The plan will include relevant portions of the Phase II Plan, set annual goals and objectives, and describe coalition wide events and other activities. It will incorporate all relevant aspects of the community intervention sites as well.

The plan will be developed by the subcommittees with the support of ASSIST staff by Month 20. It will be submitted to the Executive Committee for approval and once approved submitted to the NCI Project Officer by Day 1, Month 22, Phase I and annually thereafter.

A copy will be distributed to all members of the Coalition and promoted through numerous channels - newsletters, media, meetings and others.

5.3.4 Task 12: Training

5.3.4.1 Make Use of National ASSIST Training Opportunities

As in Task #6, this will be coordinated by the subcontractor, the University of Southern Maine, Human Services Development Institute, in conjunction with Maine Project ASSIST staff. Coalition representatives will be selected to attend national training sessions. University of Southern Maine/HSDI staff will be responsible for an ongoing training needs assessment which includes this task.

5.3.4.2 Participate in Information Exchange Mechanisms

The subcontractor will, as in 12-A, coordinate this task. The University's ITV System will be utilized to disseminate information throughout the state from the biannual Information Exchange Conference. In addition, information for these conferences will be

presented to the American Cancer Society, Maine Division, Inc. Board of Director's meeting and to the Department of Human Services' Cancer Prevention and Control Advisory Committee.

Information on the conferences will be disseminated through the ASSIST newsletter, the Division of Health Promotion and Education's newsletter Maine Health Promoter as well as other newsletters. Ready to print articles will be developed for Coalition member's newsletters.

The Project will coordinate the collection, development and submission of examples of smoking prevention and control activities to the Project ASSIST Office for publication in a casebook.

5.3.5 Task 13: Monitor Intervention Activities

The collection and maintenance of program activities, and the provision of progress reports to Coalition members will entail virtually the same procedures as Task 7 Phase I monitoring. It will be implemented as per the description of 7.

The Maine Project ASSIST will prepare and deliver an annual review of Coalition activities. Project staff will be responsible for this task based on the Project monitoring system. The subcommittees and technical resource groups will submit needed information to Maine Project ASSIST staff. The staff will develop a draft of the review based on the working groups and community intervention site activities by Day 1, Month 12. The Advisory Committee will review and comment on the draft Annual Review by Month 12, Day 14. The Executive Committee will approve the Annual Review and submit the final copy to the NCI Project Officer by Day 1, Month 13. This process will be repeated annually thereafter.

5.3.6 Task 14: Administrative Committees

The Maine Project ASSIST Director will attend all Coordinating Committee meetings, serve on project-wide subcommittees, task forces or other project-wide administrative meetings. In the case where the Project Director cannot attend, a representative of the Project will be appointed to attend.

VI. MAINE ASSIST COALITION

VI. MAINE ASSIST COALITION

This section describes the structure and membership of the Maine ASSIST Coalition. The Coalition is structured to maximize the use of existing resources, reach the intervention channels and target populations most efficiently and effectively, and enlist new groups and organizations into the state's tobacco prevention and control initiatives.

A coalition has been defined as "an organization of diverse interest groups that combines their human and material resources to effect a specific change the members are unable to bring about independently" (Brown 1984). The "Guide to Public Health Practice: State Health Agency Tobacco Prevention and Control Plans" published by ASTHO and the National Cancer Institute (ASTHO/NCI 1989) indicates "to successfully prevent and reduce tobacco use takes careful planning, resources, and the combined efforts of many organizations and individuals." Additionally, it has been stated:

> "Direct community involvement is essential to achieve a smoke-free society by the Year 2000. State coalitions for prevention and control of tobacco use bring together a broad range of persons and organizations to reach a common goal: reducing the prevalence of tobacco use. Coalitions can amplify state resources by involving community groups, volunteer organizations, advocacy groups, educators, and representatives of target populations. Leadership from physicians and other health officials is needed to ensure the success of community coalitions." (CDC 1990)

On coalitions, the American Cancer Society states,

> There are several advantages to forming coalitions. The first is a show of strength. By combining forces you are demonstrating that more than one or several groups of people are concerned about the same issue... Developing a coalition may allow you to spread the workload among more organizations, thus lessening the human and financial burdens on individual groups... A broad membership base also increases the networking potential for the groups (American Cancer Society 1990).

Due to the magnitude of the public health problem of tobacco use, the great significance of social and cultural aspects in its prevention and control and the tremendous resources necessary for its control, a coalition approach to tobacco control is essential. As previously stated, Maine has a strong history of using Coalitions to promote action for health. Thus, the participants in the Maine ASSIST Coalition are experienced in functioning in this manner.

This section describes the Maine ASSIST Coalition membership and structure including the Advisory Committee (and its relation to the Executive Committee), the subcommittees and technical resource groups. The Maine ASSIST Coalition structure is designed to reach the specified target populations through the intervention channels necessary for a comprehensive smoking prevention and control program.

In order to accomplish its goals, a Coalition must (a) have a structure that enables efficient and effective action-oriented functions and (b) have established, agreed upon procedures and guidelines for functioning. Coalition functional issues are described in SECTION V. Additional functional issues are presented in the section as necessary.

A structure is presented that provides for subcommittees and technical resource groups. The "Guide to Public Health Practice: State Health Agency Tobacco Prevention and Control Plans" supports this structural decision:

> "As the components needed for a comprehensive tobacco prevention and control plan are developed, the amount of time and work needed will be more than any one group or coalition can give. Subcommittees or task forces can deal with specific parts of the overall plan, draft objectives and outcomes for their portion, and provide the results of their work along with recommendations to the coalition for adoption. By allocating various tasks to smaller groups, the whole process is accelerated and the plan becomes finalized and operative much sooner. It also allows for broadening the plan's participation base and getting input from groups or interests not represented in the larger group" (ASTHO/NCI 1989).

The subcommittee structure will involve a primary subcommittee and a secondary subcommittee network. The primary subcommittee will include all those organizations and individuals with a strong interest and/or active working relation to a specific channel. It may include members who are new to tobacco prevention and control but, important for the goals of ASSIST or interested in getting more involved. The

primary subcommittee will have major responsibility for the smoking prevention and control workplan for its specific channel which will necessitate a more intensive involvement.

The secondary subcommittee will include those organizations with an interest in ASSIST, individuals or groups from specific target groups and those with less direct or intensive interest. They will receive information about ASSIST through newsletters and other communications. The involvement of secondary subcommittee members will hopefully increase over time as they gain a greater understanding of the need for a comprehensive public health approach to tobacco prevention and control.

6.1 Coalition Structure

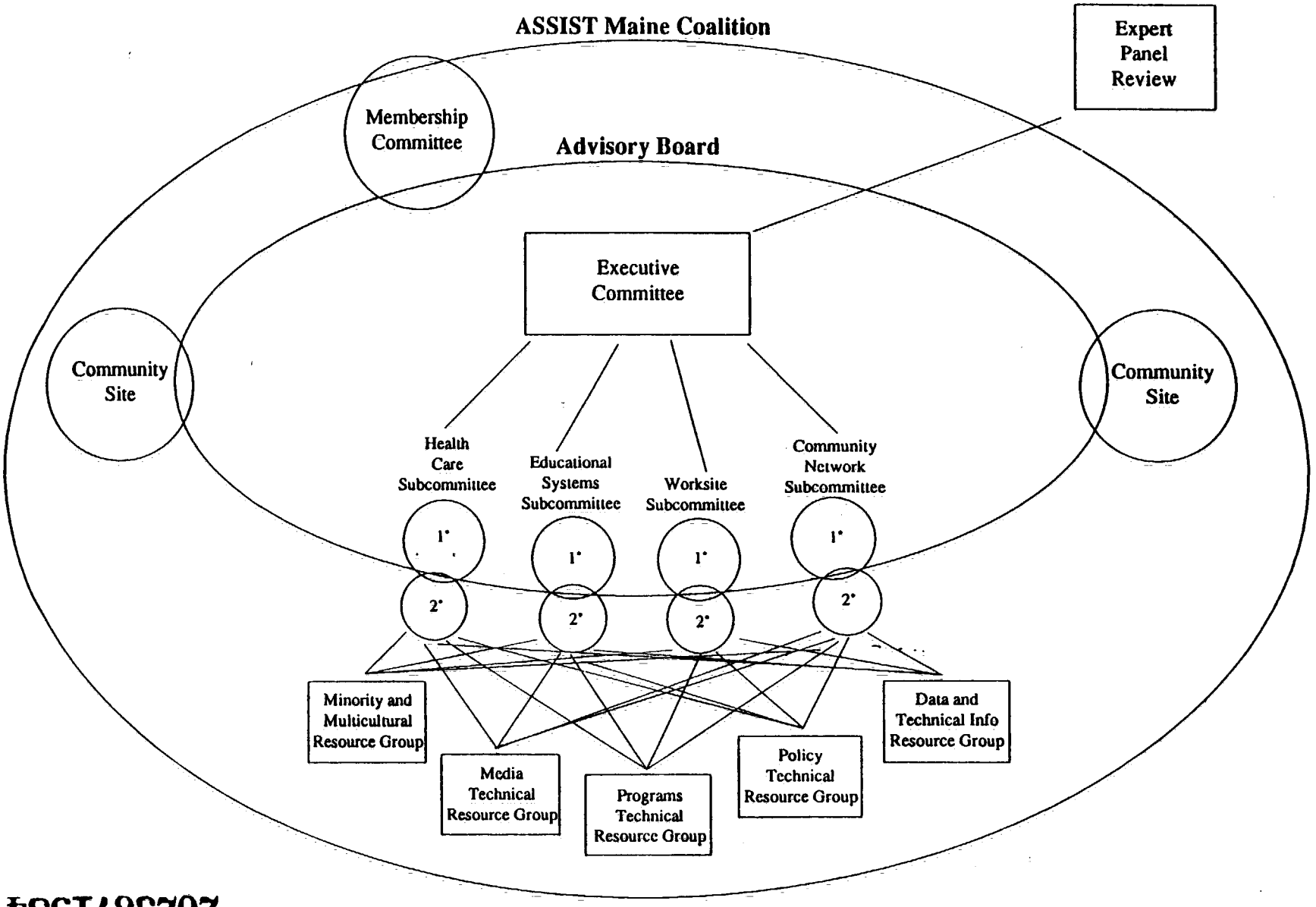
The structure of the Maine ASSIST Coalition is presented below. Numerous organizations have committed to be active participants in the Coalition. Organizations will naturally have differing levels of involvement which the structure allows for. A diagram (p. 146) is followed by a detailed explanation of the structural components.

1. The membership of the Maine ASSIST Coalition is designed to address the target populations through specified intervention channels and settings. Although numerous organizations and individuals have committed to participation in the ASSIST Project, continuous attention will be paid to membership recruitment to cover gaps in the existing structure and to membership retention to make certain that participating groups continue to participate, to maximize likelihood that all relevant parties are involved, and to continuously revitalize efforts.

The Maine ASSIST Coalition is designed as a broad, diverse group consisting of many members in order to impact the tobacco problem in every aspect of community and social life. However, in order to accomplish the necessary tasks in planning and intervention the Coalition involves the following subcommittees.

6.1.1 Subcommittees

The subcommittee structure is designed around the intervention channels. However, each subcommittee will design workplans to explicitly reach target groups).



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Maine ASSIST Coalition Structure

Each subcommittee chairperson will serve on the ASSIST central Advisory Committee thus facilitating communication between subcommittees. Each subcommittee will also have a liaison to a secondary subcommittee.

Each subcommittee will have an explicit charge to address smokers in general as well as the specific high risk target populations:

- Youth
- Ethnic Minorities
- Women
- Blue-collar workers
- Less educated individuals
- Unemployed persons
- Heavy smokers
- Smokeless Tobacco Users

In addition, each subcommittee will have an explicit charge to integrate interventions related to the community environment into their work. The term "community environments" is defined as:

> "The general physical and social milieu in identified areas within the intervention site. The community environment as a channel consists of the multiple outlets in a community that reach all citizens regardless of employment, scholastic, health, social or smoking status. The presence and salience of messages promoting smoking or quitting, the availability (or lack thereof) of cigarettes and smokeless tobacco and the social norms for smoking in public places all contribute to a community environment that may or may not support smoking" (NCI 1989).

The ASSIST planning group determined that this channel, in effect, spanned all intervention channel settings. It was thus decided not to make this a separate subcommittee but to integrate the channel goals into the work of all the subcommittees.

The goals include:

- reducing the number of pro-smoking cues and messages in the community environment, including smoking in public places, cigarette advertising, tobacco-sponsored sporting and cultural events, and the widespread availability and affordability of cigarettes.

- increasing the number of cues and messages supporting non-smoking in the community environment, including the strategic use of planned media campaigns to promote non-smoking, quick and effective response to tobacco- and smoking-related news events to present the non-smoking point of view in the media, and the highly visible promotion of available program services in public places throughout the community.

6.1.1.1 Health Care System Subcommittee

Health care providers, their professional associations, health care facilities and their staff can have a significant impact on tobacco control (cessation), prevention in youth (USDHHS 1987b) and leadership in tobacco prevention and control policy issues. Research has shown that physicians play an important role in helping smokers stop through clinical interventions (Glynn and Manley 1989) and in providing leadership for tobacco control advocacy.

The charge to the Health Care Systems Subcommittee will be to develop a plan to:

- Influence health care providers to promote smoking interventions and to play a leadership role in community smoking control efforts

- Establish delivery of a brief smoking cessation intervention as a minimal standard of practice

- Assist interested professionals in becoming proficient in providing smoking cessation assistance

- Direct smokers to health care providers who are skilled in smoking cessation techniques

- Change health care facility and organization norms to support non-smoking

- Increase adoption and effective implementation of comprehensive health care facility non-smoking policies

- Increase smoking control messages within health care media

Selected members include:

Maine Ambulatory Care Coalition
Maine Consortium for Health Professions Education
American Lung Association of Maine
American Cancer Society of Maine
Maine Public Health Association
University of New England, College of Osteopathic Medicine
Various Medical Associations

Pat Jones, Public Health Educator in the Division of Health Promotion and Education will staff this subcommittee. Members for this group have been selected for their ability to influence tobacco prevention and control programs and policy through the health care system.

6.1.1.2 Educational Systems Subcommittee

The Educational Systems Subcommittee will develop the plans and intervention strategies for school-based smoking prevention and control activities carried out through private and public primary, secondary and post-secondary schools (USDHHS 1990a).

Educational systems-based interventions impact (a) curriculum, (b) school environment and (c) policies (USDHHS 1987b). Although primarily addressed toward school children, adolescents and adult learners, the school serves as a setting for worksite health promotion for faculty and staff [How healthy are your schools (Drolet 1985)] and as a focal point for community activity.

The charge to the Educational Systems Subcommittee will be to develop a plan to:

1. Delay and decrease the onset of smoking among students.

2. Increase smoking cessation among students, faculty, and staff.

3. Increase the capacity for schools to serve as effective resources for smoking prevention and cessation.

4. Increase adoption and effective implementation of comprehensive school non-smoking policies.

5. Enhance support for non-smoking in PTA's, school-related unions, and other school-based organizations.

The subcommittee will be chaired by Jan Hitchcock, Ph.D. Dr. Hitchcock is a research psychologist with extensive research experience in prevention of smoking in youth. She is formerly the Associate Director of the Institute of Smoking Behavior and Policy at Harvard University. Members of this subcommittee have been selected due to their extensive experience in working with educational systems, knowledge of prevention of smoking in youth, or ability to influence the educational systems to promote policy changes. Selected members include:

- Jane Ann McNeish, Prevention Coordinator, American Lung Association of Maine
- Department of Educational and Cultural Services, Division of Alcohol and Drug Education Services
- Maine School Boards Association
- Maine School Health Education Coalition
- Maine Elementary Principals Association

Pat Jones, Public Health Educator, will staff this subcommittee. Ms. Jones has experience in linking community health education and school health education. She served as staff of the Cessation Resources subcommittee of the Governor's Commission on Smoking OR Health.

6.1.1.3 Worksite Subcommittee

Worksites are an important channel for health promotion in general and specifically for tobacco prevention and control (USDHHS 1985a and 1985b). The National Cancer Institute states, "worksites are an important channel for smoking control because they represent a setting in which large numbers of smokers may be reached and in which smoking control activities may be promoted, cessation programs offered, and cessation attempts encouraged and supported. Worksites also are an important channel for involving non-smokers in smoking control efforts, particularly through the promotion of non-smoking policies." The National Survey of Worksite Health Promotion Activities (USDHHS 1987a) indicated that smoking control was the most frequently cited category of health promotion activity (35.6% of worksites). However, at 35.6 percent, there is still room for increased activity in this channel.

The charge to the Worksite Subcommittee will be to develop a plan to:

1. Increase cessation among workers who smoke.

2. Increase the capacity for worksites to serve as effective agents of smoking control.

3. Increase adoption and effective implementation of comprehensive worksite non-smoking policies.

4. Enhance support for non-smoking in the business and labor sectors of the community.

The Worksites Subcommittee will be chaired by Sarah MacColl who has extensive experience in worksite health promotion. Ms. MacColl is the coordinator of the Wellness Council, Healthworks and the Portland Public Library HealthShare Program. She is President of the Board of the American Lung Association of Maine. Members of this committee are selected because of their extensive experience in worksite or occupational health, or because of their ability to provide leadership in influencing worksite health promotion and tobacco control policies. Selected members include:

- Bath Iron Works
- Bureau of State Employee Health
- Maine Labor Group on Health
- American Lung Association of Maine
- American Cancer Society, Maine Division, Inc.
- American Heart Association of Maine
- Bureau of Employment Security

The subcommittee will be staffed by Karen Sokol, MPH, Public Health Educator in the Division of Health Promotion and Education.

6.1.1.4 Community Networks Subcommittee

A number of studies and programs indicate the strong influence of community and social networks in supporting health behavior change. The large community heart disease prevention programs such as the Pawtucket Heart Health Program and the Minnesota Heart Health Program (Mittelmark, et al. 1986 and Lefebvre, et al. 1987) have provided evidence of the importance of comprehensive community involvement in health behavior change. A number of social and cultural forces influence the decision to initiate smoking or the decision to quit (Erikson 1988, and Syme and Alcalay 1982).

According to the National Cancer Institute, "community networks are an important channel for smoking prevention and control because they provide an opportunity to reach individuals who may not be reached through health care settings, worksites, or schools" (USDHHS 1989b). Those individuals at high risk, but unreachable through other channels, such as school dropouts, may be addressed through other community networks.

The charge to the Community Networks Subcommittee will be to develop a plan to:

1. Increase cessation among network members who smoke.

2. Build the capacity of community networks to serve as effective agents of smoking prevention and control.

3. Increase adoption and effective implementation of comprehensive non-smoking policies where appropriate.

4. Enhance support for non-smoking in community networks.

The Community Networks Subcommittee will be chaired by Edward Miller, MSEd, Executive Director of the American Lung Association of Maine. Mr. Miller has extensive experience in tobacco prevention and control at all levels. He was formerly the Director of the Division of Health Promotion and Education in the Maine Bureau of Health in which he played a central role in integrating tobacco control into the Bureau's work, has served as subcommittee chair of the Prevention and Youth Subcommittee of the Governor's Commission on Smoking OR Health, is a founding member of the Maine Coalition on Smoking OR Health, has delivered smoking cessation interventions at a rural health center and has trained group leaders in smoking cessation.

The Community Networks Subcommittee will be staffed by the ASSIST Field Director (to be named).

6.1.2 Technical Resource Groups (TRGs)

Three specific workgroups will be convened to provide oversight, consultation and technical assistance on interventions utilizing (a) media, (b) policy and (c) program services in each of the intervention channels. Each TRG will work with the subcommittees to integrate relevant aspects of the NCI standards (recommended activities, strategies, tracking measures into the subcommittee's plan development).

Additional resource groups to be convened include (a) the Data and Technical Information Group and (b) the Minority and Multi-Cultural

Resource Group. Each TRG will assist all subcommittees and the Advisory Committee and will thus be available for project-wide support. A detailed explanation of the rationale, role and function of each workgroup follows.

6.1.2.1 Media Technical Resource Group

Media and communications are important strategies for health promotion. According to the Office of Cancer Communications, National Cancer Institute, "Communication plays an essential role in disease prevention and health promotion. Programs designed to promote changes in health behaviors... have demonstrated that mass media and other communication strategies can be effective in reducing the risk of serious illness" (USDHHS 1989a).

Flay (1987a) states:

> "mass media programs and campaigns have been used in three major ways to influence smoking related knowledge, attitudes, and behaviors: to inform the public of the negative health consequences of cigarette smoking and to try to motivate existing smokers to quit; to promote specific smoking cessation actions to those smokers motivated to quit; and to provide smoking cessation 'self-help clinics' to those smokers who desire to quit."

As stated by the National Cancer Institute, Smoking Tobacco and Cancer Program 1985 Report (USDHHS 1986) "the mass media has substantial influence on our lives. Just as the media is used to affect our purchasing behaviors, it can also be utilized to foster healthy lifestyles. Messages that are aimed at the prevention and cessation of tobacco use and delivered through the media not only reach thousands of tobacco users at one time but can promote the non-use of tobacco products."

In addition, the use of "media advocacy" has become an important tool in the fight against tobacco (USDHHS 1989b, and Eriksen et al. 1990). Media advocacy is defined as the strategic use of mass media as a resource for advancing a social or public policy initiative.

According to the National Cancer Institute (1989), "the primary goal of mass media interventions in a comprehensive smoking prevention and control effort are to support non smoking behavior, increase motivation to stop smoking, and enhance public support for policy changes that support smoking control."

The Media TRG will work with the four intervention channel subcommittees. These group's charge will be to integrate the following goals into the subcommittee's work with particular emphasis on specified target populations. The specific (NCI 1989) of media-related activities are to:

1. Provide information to the public regarding the facts and issues about smoking, including availability of cessation program services and smoking-related events.

2. Motivate people to stop smoking or prevent them from starting to smoke.

3. Set the public agenda and generate public discussion by placing smoking in its proper perspective as a health issue.

4. Generate broad public support for non-smoking policies and make policymakers aware of this support.

5. Recruit smokers into treatment programs.

6. Conduct smoking cessation courses.

The ASSIST Project will utilize already developed electronic and print media whenever possible.

The Chair of the Media TRG will be selected within the first two months of Phase I. It will be staffed by the Field Director (to be named).

6.1.2.2 Programs Technical Resource Group

Media and policy interventions are accompanied by, complement and promote "a wide range of program services that guide and support individuals in making those changes. Most program services are delivered via the identified channels for smoking prevention and control, that is, through the health care system, worksites, schools and community networks" (USDHHS 1989b).

Program services fall into three categories: (a) cessation resources, (b) prevention resources, and (c) smoking education.

NCI research indicates that "self help/minimal intervention strategies for smoking cessation may be the preferred means by which smokers stop and can produce success rates approximately those of more formal programs, at lower cost and with greater access to relevant populations" (Glynn et al. 1989). An Expert Advisory Committee convened by NCI identified "essential elements of self-help/minimal

intervention strategies for smoking cessation." The panel indicated "many effective programs for smoking cessation have been developed... and resources can be most effectively used by promoting their distribution and use..." (Glynn et al. 1989). This TRG will utilize the recommendations of the Expert Advisory Committee and will promote existing programs as indicated in the above recommendation.

The TRG will also provide technical assistance to the subcommittees on (a) prevention services to prevent initiation and school-based programs utilizing "School Programs to Prevention Smoking: The National Cancer Institute Guide to Strategies that Succeed" (1990) and (b) smoking education workshops and program services. They will also work with each subcommittee to integrate the following goal into the subcommittees' work, with particular emphasis on the specified target population:

> "to ensure the high visibility and ready availability of materials and programs that support individual behavior changes consistent with the non-smoking norms" (USDHHS 1989b).

The Program TRG will be chaired by Joanne Bean, RN, MBA. Ms. Bean is the Health Promotion/Patient Education Coordinator at Kennebec Valley Medical Center in Augusta. She is Chair of the American Cancer Society, Maine Division, Inc. Public Education Committee. It will be staffed by American Cancer Society ASSIST staff.

6.1.2.3 Policy Technical Resource Group

It is widely recognized that a comprehensive tobacco prevention and control program includes policy-directed interventions (Breslow 1982, Wynder 1988, USDHHS 1989, ASTHO/NCI 1989, and Iverson 1987). Steckler and Dawson define health policy as "a subset of social policy designed to have an impact on the delivery of health care services or otherwise directly affect the health of population groups" (Steckler and Dawson 1982).

Policy approaches may be directed at the individual, organizational or governmental level (Simons-Morton et al. 1988). Policy approaches may be implemented by governments, private organizations and businesses. In tobacco prevention and control they may be directed toward prevention or reduction of tobacco use or protection from involuntary exposure to environmental tobacco smoke (USEPA 1989) Breslow (1982) identified ten action alternatives for governmental smoking control. These are: prohibition, restriction of cigarette smoking, reduction of hazardous substances in cigarette smoke, restrictions on advertising cigarettes, public information, education, aid to persons who want to quit, taxation and other economic measures, international cooperation and research.

The Policy TRG will work with the four subcommittees to integrate the following goals into their work, with particular emphasis on the specified target populations. The policy-directed goals are to:

1. Ensure safe, smoke-free environments for the public and reinforce social norms and values supporting non-smoking.

2. Provide stimuli and incentives to help smokers stop and offer structural support to help them remain smoke free.

3. Provide incentives for people to never begin smoking.

Types of policies which will be developed include but are not limited to: (USDHHS 1989b)

1. Clean indoor air
2. Restricting access to tobacco by minors
3. Economic incentives and taxation
4. School-based prevention curricula
5. Restricting advertising and promotion of tobacco

The Policy TRG will be chaired by Gordon Smith, Esq. Mr. Smith is Legal Counsel for the Maine Medical Association. He has served as Chair of the Maine Coalition on Smoking OR Health and the Governor's Commission on Smoking OR Health. A copy of his C.V. and letter of commitment is attached in the Appendix. It will be staffed by the Division of Health Promotion and Education ASSIST Staff.

6.1.2.4 Minority and Multi-Cultural Technical Resource Group

Cultural and ethnic minorities are an important target population for tobacco prevention and control programs. In Maine, Native-Americans and Franco-Americans constitute the two significant ethnic minorities. Data from the 1980 Maine Hypertension Household Survey indicate a high prevalence of female smokers in the Franco-American Population (44%). A survey of the Penobscot Indians (through the CDC funded Community Chronic Disease Prevention Program) indicates a high prevalence (54%) of tobacco-use.

The Minority and Multi-Cultural TRG will provide consultation, advice and technical assistance to the Coalition and all subcommittees on the cultural aspects of health promotion and tobacco control in their communities. It will also serve as a liaison with the ethnic communities. It will be composed of representatives from the Native-American tribes and the Franco-American Community. Representation of the ethnic community members in all aspects of the ASSIST Project is essential. A report done for the National Heart, Lung and Blood Institute indicated the importance of community involvement in diffusion strategies for culturally diverse populations:

> "Members of ethnic and cultural minorities often cluster in communities that provide some measure of social support or maintain extended social networks. People from the same ethnic group typically share beliefs, values, and social and educational experiences. This shared reality suggests that diffusion strategies developed for and with the community will be more effective than those planned and implemented solely by agencies at the national, state or municipal level" (USDHHS 1987c).

The Minority and Multi-Cultural TRG will be established from committees with the same focus currently organized through the Katahdin Area Health Education Center. The TRG will provide oversight on minority issues to all aspects of the ASSIST Project. The group chair will be selected from the existing committee. Dr. Sandra Hoover will staff the Group.

6.1.2.5 Data and Technical Information Resource Group

This small resource group will be composed of individuals who are experienced in data usage, analysis statistics and epidemiology. They will be responsible for translating national and state trends, survey research findings and technical information. Their translation will be in a language and format which will be understandable and meet the needs of Coalition members, the subcommittees, and the general public (function is specified in tasks 10 and 11). Members will include staff of the Bureau of Health, voluntary health agencies and others.

6.1.3 Membership Committee

The Membership Committee will play an integral role in the recruitment of new members and the retention of existing Coalition members. They will ensure that all relevant organizations are involved, that participating groups continue to be active, and continuously revitalize efforts. The committee will develop a plan for its recruitment and retention

activities immediately in month 1 of Phase I. The plan will include, (among other activities) an orientation to the ASSIST Program, input into the Maine ASSIST Handbook, a schedule of ASSIST presentations to various groups, development of regional ASSIST membership representatives (since Maine is such a large state), a possible brief "Introduction to ASSIST" video (or slide show and/or audiotape which can be easily reproduced), printed material on how to join, and other activities.

The Membership Committee will utilize the framework for channels, interventions and target populations to assess membership gaps and develop plans to address those gaps.

A dissemination plan for all the above activities will be developed, submitted to the Advisory Committee and approved by the Executive Committee. The Membership Committee Chairperson will be selected from among the Advisory Committee members. The Field Director (to be named) will staff the Committee.

6.1.4 Advisory Committee

The ASSIST Advisory Committee links the ASSIST Executive Committee, the subcommittees and Resource Groups, the Community Intervention sites, and the large coalition. It is the mediating body which: (a) provides advice to the Executive Committee on project policy issues, (b) links the activities of the committees and resource groups, and (c) forms the link for communication and coordination with the larger Coalition.

The Advisory Committee will include the following:

1. The Executive Committee members
2. Two representatives from each community intervention site
3. The chairperson of each subcommittee
4. The chairperson of each resource workgroup
5. Five at large members

The Advisory Committee will meet quarterly. The agenda will be set to include:

1. Executive Committee report including NCI ASSIST information
2. Community Intervention Site report
3. Subcommittee and Technical Resource Group report

4. Necessary informational, educational or consultation session (with guest faculty, consultants, or presentations as necessary or appropriate)

5. Time for subcommittee interaction and plan development

6. Other

Details of the Advisory Committee management have been described in the Section V.

6.1.5 Executive Committee

The ASSIST Executive Committee will be formed to coordinate and manage the project. The Executive Committee will be the major policy body for Project management. It will set planning and budget parameters, determine program direction, set program goals, approve overall coalition plans as recommended by the coalition, and supervise implementation of the coalition plans.

The Executive Committee will include from the Maine Bureau of Health:

- Randy Schwartz, MSPH, Director, Division of Health Promotion and Education, ASSIST Project Director (Mr. Schwartz's experience is described in detail in the personnel section.)

- Sandra Hoover, PhD, MPH, Project Manager (Dr. Hoover's experience is described in detail in the personnel section.)

- Lani Graham, MD, MPH, Director, Maine Bureau of Health (State Health Officer) - Dr. Graham is the State Health Officer for Maine. She has experience as a local health officer and was previously Director of the Division of Disease Control in the Maine Bureau of Health. Dr. Graham is the Principal Investigator of the Maine Breast Cancer Control Project. She has experience in communicable and chronic disease public health interventions. She is trained in family practice.

- Beverly Entwhistle, RDH, MPH, Director, Office of Dental Health - Beverly Entwhistle is currently Director, Department of Human Services' Office of Dental Health. Previously she was Associate Professor at University of Colorado School of Dentistry, Department of Applied Dentistry, teaching public health, geriatrics and special patient care, as well as directing the Dental Extramural Program. Ms. Entwhistle is active in AAPHD and ASTDD, and will serve as the Program chair for the Dental Health Section of APHA for 1991-92.

From the American Cancer Society, Maine Division, Inc:

- Alan Anthony, Executive Vice President - During his twenty years with the American Cancer Society, he has been involved with a variety of smoking/lung education programs. He was instrumental in the formation of the HOT (Health or Tobacco) Coalition. Alan's particular expertise is in legislative issues.

- Vicki Purgavie, Public Education Director - Vicki has been a staff member with the American Cancer Society for over six years. Her primary responsibility is with Public Education. She currently serves as secretary for the Maine School Health Education Coalition (MeSHEC) and holds memberships with the Maine Public Health Association (MPHA) and the Maine Association of Health, Physical Education, Recreation and Dance (MAHPERD).

- Donald Magioncalda, MD, ACS President - Dr. Magioncalda is an oncology specialist at Kennebec Valley Medical Center in Augusta. He chairs the Maine Cancer Prevention and Control Advisory Committee and is a member of the Governor's Commission on Smoking OR Health.

- Joanne Bean, RN, MBA, ACS Public Education Committee Chairperson - Joanne is the Health Promotion Coordinator at Kennebec Valley Medical Center. She holds her B.S.N. and M.B.A. In 1989, Joanne received the Jaycees Outstanding Young Mainers Award. Currently, she is President of Kennebec Valley Hospice and the Maine State Patient Education Forum, as well as a member of the legislative committee for the Maine Public Health Association (M.P.H.A.).

Additional members:

- Edward Miller, MSEd, Executive Director, American Lung Association of Maine

- John McNeill, Executive Vice President, American Heart Association, Maine Affiliate.

The Tri-Agency Coalition in Maine along with the Bureau of Health, has formed the nucleus for tobacco prevention and control initiatives. Inclusion of Mr. Miller and Mr. McNeill on the Executive Committee demonstrates the commitment to making the ASSIST Project a success in Maine and to the understanding of the magnitude of the problem and the clear need for an integrated, cooperative approach.

Functional aspects of the Executive Committee have been described in greater detail in Section V.

6.2 Selected Representative Coalition Members

6.2.1 UNUM Life Insurance Company

Organizational Mission - Speciality, risk-relieving financial institution

Representative Activities - Comprehensive, high quality and effective health promotion programs to employees, particularly smoking cessation. Smokefree since 1986, that year, one of four insurance companies nationally.

Constituency - 3000 UNUM employees (70% female, clerical production jobs) in Maine are reached through smoking cessation planning, nonsmoking policy, wellness fitness facility, and individualized health/health behavior programs.

Committees - Program Service.

6.2.2 Cancer Information Service

Organizational Mission - Provides cancer information via public access toll-free service.

Representative Activities - Can provide technical resource groups, distribute NCI materials and resources, share media resources, and monitor response (tracking calls to 1-800-4-CANCER) for data generation for evaluation.

Constituency - General public, health professionals

Committees - Community Network, Program Services

6.2.3 Maine Public Health Association

Organizational Mission - To protect and promote public, personal, and environmental health with public health issues education, public health advocacy, professional (personal and organizational) association activities to promote public health, and training and education promotion and assistance, including professional development.

Representative Activities - Statewide conferences, public forums, quarterly newsletter for advocacy, and professional resources

Constituency - 300 members: administrators and health professionals, dentists, dietitians, educators, nurses, pharmacists, physicians, psychologists, researchers, toxicologists and local health officers

Can serve through newsletter, legislative alert publication, conferences, public forums, and lobbying efforts

Committees: Legislative, Program Planning, Membership, and Community Network

6.2.4 Maine Labor Group on Health

Organizational Mission - Education for health and safety in the workplace, health care advocacy

Constituency - Workers, labor unions, health professionals, community and labor individuals; 2,600 in Maine and New Hampshire.

Representative Activities - Statewide health and safety training (since 1977), represents 8000 Maine workers, has capacity to develop research, quarterly newsletter provides direct information, Right to know legislation pioneering. Coalition involvement led to state legislation to reduce toxic materials in the workplace, reduce unregulated air emissions, and to mandate lessening of hazardous waste production.

Committees - worksite

6.2.5 Medical Care Development

Organizational Mission - Develop and operate service and educational programs; conduct research and health policy analysis for health and health care improvement.

Representative Activities - Statewide program development, i.e. hypertension, diabetes controls; emergency care; breast cancer and expansion of delivery of substance abuse preventions.

Constituency - Provider agencies, hospitals, physicians. Reaches constituents through organizations, direct contact. 50 employees: specialists, particularly in public health, telecommunications, education, health systems, and long term care.

Committees - Health Care, Data and Information Technical Workgroup

6.2.6 Katahdin Area Health Education Center

Organizational Mission - Education of health professionals and educational support to health professions in rural areas.

Representative Activities - Works with rural practitioners and with health care facilities in rural community-based programs for professional education.

Constituency - Rural health professionals

Committees - Health Care, Program Services

6.2.7 Healthworks, The Wellness Council of Southern Maine, United Way, Inc.

Organizational Mission - In part, to help employers implement and/or enhance worksite wellness programs using a representative from worksite to Healthworks.

Representative Activities - Collaboration with employers for smoking cessation, indoor air quality, smokefree society promotion.

Constituency - 20,000 employees, Greater Portland, 22 worksites

- Strategic planning
- Organizing worksites to address community health problems via employer volunteerism and financial commitment.
- Idea exchanges, networks
- Newsletter; disseminates information strategies at meetings and workshops for employers' health/wellness staff for smoking intervention, control and prevention.
- Clearinghouse capacity to pool resources from present employers' policies, efforts, and successes to assist other employers.
- Mailing list.

Committees - Worksite Community Network.

6.2.8 Family Planning Association of Maine

Organizational Mission - Assurance of delivery of comprehensive, coordinated, cost efficient, high quality family planning to the people of Maine.

Representative Activities - Clinical and educational services (one on one intervention), advocacy/training, group presentations and trainings, continuing education for health care professionals.

Constituency - 33,000 clients annually. Education of 20,000 parents and professionals. Majority of clients are women at 150% of poverty or below.

- Statewide network of 40 clinics
- Nurse practitioners in preventive model of health care provision (26 to 30 NPs, counselors).
- Preventive health screening and counseling.

- hypertension, cholesterol, anemia, nutrition, smoking, substance abuse, sexual and physical abuse, STD services.

High priority given to smoking prevention and interventions. All clients receive attention on issue of smoking.

Personal risk assessment made with each client, with cessation interactions as appropriate.

Committees - Health Care and Community Network

6.2.9 Christian Civic League of Maine

Organizational Mission - Improvement of quality of human life through political action. This religious organization, on several levels, opposes all use of tobacco.

Representative Activities - lobbyying, constituent services

Constituency - "Christian families, churches and individuals in Maine."
Reaches constituency via lobbying, public speaking, informative letters, telephone calls and monthly newsletters. Staff: six (nonsmoking worksite).

Committees - Community Network.

6.2.10 Catholic Schools Office Roman Catholic Diocese - Catholic Schools

Organizational Mission - Catholic education via 24 Catholic schools in Maine.

Representative Activities - Curricular and extra curricular school activities.

Constituency - 5000 students, parents, families; 350 teachers, principals, families. Parishioners of more than 24 parishes are reached via administrative informational letters and school staff meetings.

Committees - Education and Community Network.

6.2.11 Maine Radio and Television Company (WCSH-TV)

Organizational Mission - Service of health information to public.

Representative Activities - The only full time health reporter in Maine. Welcoming news opportunities, public affairs and public service, call in shows and documentaries (public service productions).

Constituency - Maine residents in the listening/watching area of southern Maine to central Maine.

Committees - Media Workgroup, Community Network

6.2.12 Maine Elementary Principals Association

Organizational Mission - Supporting elementary principals with resources; to fill educational leadership roles; to be childhood advocates.

Representative Activities - Newsletters, conferences, lobbying and publications.

Constituency - Serve elementary and middle level principals of 350 members with newsletters, conferences and committee work.

Committees - Education and Community Network.

6.2.13 University of New England Area Health Education Center Program (AHEC)

Organizational Mission - "Improvement of primary health care for Maine's rural people" and to link professional health education to rural health care providers.

Representative Activities - Clinical training of health professions students, continuing professional education, technical assistance to communities and rural providers, health promotion/disease prevention, smoking cessation/prevention/control. Technical assistance provided to rural primary care providers of patient education, patient educational resources, initiating a statewide coalition to develop low literacy appropriate patient educational materials.

Constituency - Currently affiliated with 50 rural primary care physicians and 20 hospitals/community health centers.

A presence currently in Franklin County. Can support ASSIST via health educator/regional coordinator.

Committees - Program Services, Health Care.

6.2.14 City of Portland, Public Health Division, Health and Human Services Department

Organizational Mission - Delivery of public health services, Health Promotion and Disease Prevention are "overriding principles."

Representative Activities - Primary health care clinics (children, homeless adults), dental health education (K-6) and STD/HIV clinics, screening services, elderly health promotion, health education, community networking.

Constituency - Low income women, children (neo-natal to 21), refugees, blue collar, elderly, AFDC families, homeless. Constiutuency served through home visits, school education, clinics, community events, media, community groups (neighborhoods), health education classes. Staff of 48. Willing to implement ASSIST with local implementation plan.

Committees - Advisory; also local intervention site

6.2.15 American Heart Association, Maine Affiliate, Inc.

Organizational Mission - Reduction of risk factors for death from cardiovascular disease and stroke.

Representative Activities - The American Heart Association developed materials and programs -- "programs specifically addressing smoking and others which focus on multiple risk factor interventions." Specific worksite AHA program exists. Trainings and presentations of AHA programs can be arranged in Portland and Franklin County.

Constituency - Public via educational materials and trained lay volunteers and professionals. Reaches large numbers - third largest voluntary health agency in Maine. Network of thousands of health professionals and lay volunteers.

Committees - Education, Community Network Worksite, Executive

6.2.16 Maine Department of Educational and Cultural Services Office of Truancy, Dropout and Alternative Education

Organizational Mission - By legislative act, to provide technical services to schools (public and private) relating to dropout prevention.

Representative Activities - Workshops, school program assessments, seminars, newsletters, and other publications.

Constituency - A sizeable school population of underachieving, at risk students in Maine who lack self esteem and positive role models.

Committees - Education and Community Network.

6.2.17 Maine School Boards Association

Organizational Mission - To represent and serve school boards in Maine in supportive functions.

Representative Activities - general consulting services, legal services, legislative services, and workshops. Can furnish mailing list/labels of school boards.

Constituency - 270 Maine school boards.

Committees - Education.

6.2.18 Maine Cardiovascular Health Council

Organizational Mission - To promote cardiovascular health and risk reduction in Maine, with recognition of smoking as a major risk factor. To serve as the advising council to Maine Bureau of Health Community Cardiovascular Risk Reduction Program.

Representative Activities - Quarterly newsletter, Annual Statewide Educational Symposium (can include tobacco use), advocacy, standard settings and educational programs, training programs, legislative advocacy.
Can serve in planning and advisory capacities.

Constituency - Health professionals education mainly in cardiovascular risk reduction - direct interventions via physicians.

Committees - Program, Policy, Health Care, Worksites and Community Network.

6.2.19 Healthshare - Consumer Health Information, Portland Public Library

Organizational Mission - To provide the public with information to improve health and cope with disease, as complement to professional health care.

Representative Activities - Over $300,000 has been expended to promote personal health since 1987; is an educational resource (acquisition, distribution and reference services); provides Health and Human Care Directory for Southern Maine via patron accessible computer, interactive program in library learning center; Healthline - telephone access to recorded information (to include smoking cessation), workshops and health fairs in collaboration with other agencies.

Constituency - 50,000 people with access to Portland Public Library. Interlibrary loan expands service statewide by health professionals' offices, health agencies, media, worksites and schools.

Committees - Education and Community Network.

6.2.20 Maine School Health Education Coalition

Organizational Mission - To strengthen health education in Maine schools K-12.

Representative Activities - Regional advocacy for school health education teacher training to strengthen health teacher certification standards, to upgrade curricula and teacher (individual) training. Newsletters, coalition meetings, professional health education conferences, brochures, courses and workshops.

Constituency - health teachers in Maine (certified and those seeking certification. Prospective teachers, community advocacy groups for comprehensive school health education. Community advocacy groups for comprehensive school health education.

Regional advocacy task force in Greater Portland. Teacher training task force in Farmington in Franklin County. Wellness Conference annually. UM Courses.

Committees - Community Network (staff coordinator) and Education.

6.2.21 Maine Association of School Nurses

Organizational Mission - To work for the health and safety of the school aged child in Maine - promotion of quality health program delivery, strengthening school nurses professional growth and advancing practice of school health nursing.

Representative Activities - Board of Directors, membership 21; Executive Committee; Standing Committee 10; network of 5 geographic regions; active telephone call method - 300 reachable in one day School health nurses: educational and direct service.

Constituency - 300 school nurses in Maine with association membership of 300.

Committees - Education, Community Network and Health Care.

6.2.22 Maine Department of Labor, Bureau of Employment Security

Organizational Mission - to match people with jobs; no charge to employers or applicants, as a State agency. "Bringing good people and good jobs together."

Representative Activities - applicant services and employer services - computerized matching system.

Constituency - 7,000 employers and 100,000 job seekers served by Job Service and all employers and job seekers in State via network of 17 local offices. Ninety employees in Job Service. Question number impacted by tobacco use in this "mix" of employees - some clerical, etc.

Committees - Worksite and Community Network.

6.2.23 Maine Consortium for Health Professions Education

Organizational Mission - The improvement of physical and mental well being of the people of Maine through the education and development of health care providers.

Representative Activities - Continuing education programs, forums, AIDS education/training via meetings, forums, newsletters, mailings and education programs. Facilitates programming for: prioritization of educational needs, avoidance of duplication and economic efficiency.

Constituency - Fifty one consortium members having direct contact with smokers. Direct care providers - hospitals/home health care; universities/colleges; professional associations; trade associations - health care providers and voluntary agencies.

Organizations worksite and meetings, programs are all covered by a No-smoking policy.

Committees - Education, Health Care, and Community Networking.

6.2.24 American Lung Association

Organizational Mission - Prevention of lung disease and the promotion of respiratory health.

Representative Activities - Smoking prevention and control, as an American Lung Association program area - Farmington Cooperative Health Education Committee and worksites in Portland area. Delivery of smoking prevention and control intervention, training of program facilitators, Maine Events Newsletter reaches 3-5,000 6 times per year, and participation in ASSIST Coalition.

Committees - Educational Systems, Community Network, Program Services, Policy, Advisory, Executive

6.2.25 Penobscot Indian Nation

Organizational Mission - Concern for health and growth and total well being of individuals within the Penobscot Indian Nation as well as that of the Nation as a whole. (Reinforcement of each individual's personal identity, self respect and internal dignity.) This concern is stated in terms of wellness rather that correction of pathology.

Representative Activities - Participated in Behavioral Risk Survey in 1988. Direct services to population of the Nation via its Health Center including: medical, dental, nutrition, diabetes control and prevention; environmental health; community and home health care; health promotion/disease prevention; substance abuse. They offer: clinics, monthly newsletter, fliers, bulletin board and poster displays.

Constituency - Service population of Penobscot Indians and other eligible persons of 1,300. Fifty-four percent smoking prevalence rate, (Behavioral Risk Survey, 1988). No Smoking Policy in place at clinic. Capacity to exchange information with other Indian tribes and can provide a forum for other Indian tribes.

Committees - Program Service, Community Networking, Minority and Multicultural Resource Group

6.2.26 University of Maine Cooperative Extension

Organizational Mission - To help Maine people improve their lives through an educational process using research-based knowledge, focused on issues and needs. The organization also promotes, supports and encourages cooperation with other agencies.

Representative Activities - Educational programs, including a holistic wellness approach as well as high risk programs: family nutrition, diet, health, courses, workshops, newsletters, self study packages, support groups, multi media presentations.

Constituency - General Maine population

Committees - Education, Community Network, Program Service

6.2.27 Katahdin Area Council, Boy Scouts of America, Inc.

Organizational Mission - Not stated in letter.

Representative Activities - Scouting activities address developmental needs of youth - variety of educational pieces, inform leaders and young people of available educational material.

Constituency - 7,500 registered youth members and adult leaders in northeastern Maine - 6 counties - ages K-12 high school.

Committees - Program Service, Community Network, Educational Systems

VII. STATE HEALTH AGENCY QUALIFICATIONS

VII. STATE HEALTH AGENCY QUALIFICATIONS

The Bureau of Health within the Maine Department of Human Services is the official state health agency for Maine. The Director of the Bureau of Health is the State Health Officer. In Maine, there are no county health departments and only a few cities have official public health agencies (Portland is one of those cities). Therefore, the Maine Bureau of Health serves as the chief public health agency throughout Maine. Much of the public health field work is done in cooperation with private/non-profit health organizations including such entities as hospitals, home health agencies and rural health centers.

The purpose of the Bureau of Health "is to preserve, protect and promote the health and well-being of the population through the organization and delivery of services designed to reduce the risk of disease by: (1) modifying physiological and behavioral characteristics of population groups ("hosts" of disease); (2) controlling environmental hazards to human health ("agents" of disease); and promoting health/wellness through education, counseling and access to health services." (Maine State Government, Annual Report, 1988-1989).

The programs of the Bureau are carried out within the various divisions and offices. These include: the Division of Health Promotion and Education, the Division of Disease Control, the Division of Maternal and Child Health, the Division of Health Engineering, the Division of Public Health Laboratories, the Division of Public Health Nursing, the Office of Dental Health and the Bureau's Administration.

The Director of the Bureau of Health functions as the State's Health Officer. In addition to overseeing the Bureau's programs, the Director is instrumental in further developing cooperative relationships with the medical and public health communities in the State and in the nation. The Director represents the Bureau of Health's interests through active participation in the work of numerous state boards, committees and organizations, and at the national level through membership in the Association of State and Territorial Health Officials (ASTHO). In addition, the Division Directors are active on numerous state boards and committees and represent the state on the respective ASTHO affiliates such as the Association of State and Territorial Directors of Public Health Education.

As a Bureau within the Department of Human Services, the Bureau of Health has access to and support of a number of Department level resources including the Office of Public and Legislative Affairs (OPLA). The purpose of this Office is to maintain regular contact with the press, radio and television media, consumer groups, other

agencies and community associations; to prepare departmental information for legislative issues at the local, state and national level and to maintain a liaison to monitoring legislation affecting the department.

The Department's Office of Management and Budget provides general administrative and financial management services for the entire department. These include: The Division of Financial Services which is responsible for all general accounting services, payment of invoices, preparation of federal financial reports; the Division of Audit, responsible for auditing all funding of the Department that requires audits; the Division of Personnel and Labor Relations; the Staff Education and Training Unit; the Division of Data Processing; the Division of Plant and Office Services; and the Affirmative Action Officer and other departmental support services.

In 1986, the Bureau of Health developed the Maine Plan for Public Health, which details the goals and objectives of the Bureau in the areas of family planning, sexually transmitted diseases, immunization, infectious diseases surveillance and control, oral diseases, pregnancy, infant and child health, exercise and physical fitness, nutrition, injury prevention and control, control of stress and violent behavior, tobacco use, chronic diseases, and environmental health and sanitation. The plan includes objectives targeted for 1990 and priorities for Bureau programs.

In 1989 and 1990, the Bureau has focused on broadening the planning process to include data from various grants and programs, as well as traditional data. This includes integration of Program Plans across division lines, such as injury control, chronic disease prevention, and environmental concerns.

Below is a listing of the Bureau's programs followed by a detailed description of the various public health intervention projects which provide extensive support for the Bureau's capacity to plan, implement, coordinate and evaluate public health and health promotion interventions.

7.1 Bureau of Health, Division Programs

Programs of the Bureau's Division include:

Division of Health Engineering:

- Community Environmental Health Program (includes surveillance of food and lodging, sanitariums, inspections, etc.)
- Drinking water program
- Radiological health program
- Wastewater and plumbing control program
- Occupational and residential health

Division of Disease Control includes:

- Infectious Disease Epidemiology
- Environmental Health Program
  - Environmental Epidemiological Assessments
  - Chronic and Sentinel Disease Surveillance System
  - Environmental Toxicology
  - Hazardous Air Pollutant Program
  - Occupational Health Program
  - Community Environmental Health Information Clearinghouse
- Cancer Incidence Registration Program
- Breast Cancer Demonstration Project
- Tuberculosis Control
- Refugee Health Assessment Project
- AIDS Program
- Sexually Transmitted Disease Program
- Immunization

Division of Maternal and Child Health:

- Prenatal Care
- Nutrition Program
- WIC Program
- Childbirth Education
- Maternity Care
- Genetic Disease Screening
- Parenting Education
- Adolescent Health Care
- School Health Services
- Handicapped Children's Program
- Medical Eye Care Program
- Family Planning Services

Office of Dental Health:

- School Dental Health Education Program
- Community Fluoridation Program
- Preschool Dental Health Education

Division of Public Health Nursing provides direct services, specifically child health services and disease control.

The Public Health Laboratory provides a variety of laboratory services such as chemical, biological or radiological analyses.

The Division of Health Promotion and Education addresses those health problems in which prevention through education is a major strategy. The Division of Health Promotion and Education will administer the ASSIST Project. The Division includes:

- Community Health Promotion/Chronic Disease Prevention Unit
  - Community Health Promotion Program
    - PATCH (Planned Approach to Community Health)
    - CCDP (Community Chronic Disease Prevention)
    - Project LEAN
    - Employee Health Forum
  - Cardiovascular Disease Risk Reduction Program
- Diabetes Control Project
- Tobacco Prevention and Control Activities
  - Workplace Smoking Act Enforcement
- DHS Library

Organizational charts for the Department of Human Services, Bureau of Health and the Division of Health Promotion and Education follow.

Department of Human Services

DIVISION OF HEALTH PROMOTION AND EDUCATION

RANDY SCHWARTZ
DIRECTOR

BARBARA BAYLES
Clerk Typist III

COMMUNITY HEALTH PROMOTION AND CHRONIC DISEASE PREVENTION PROGRAM

Sandra Hoover
Director

COMMUNITY HEALTH PROMOTION PROGRAM

PATCH
Chronic Disease
Prevention Program

Karen Sokol
Public Health Educator

Vacant
Public Health Educator

Karen Knox-Damren
Word Processor Supervisor

CARDIOVASCULAR RISK REDUCTION PROG./COMMUNITY HIGH BLOOD PRESSURE PROGRAM

Patricia Jones
Director

Smoking Prevention & Control Activities
Hypertension
Cholesterol

Charlotte Hayes
Clerk Typist II

DIABETES CONTROL PROJECT

Maryann Zaremba
Director

Ambulatory Diabetes Educ. and Follow-Up (ADEF) Program
Diabetes in Pregnancy
Eye Disease Prevention
Hypertension in Diabetes
Legislative Documents

Nona Spear
Nurse Educator

Cindy Hale
Nutrition Consultant

Laura Chaput
Data Analyst
Marilyn Rice
Word Processor Operator

DEPARTMENT OF HUMAN SERVICES LIBRARY

Maryellen Fleming
Departmental Librarian

Computer Literature Searches
Book/Article Inter-Library Loans
Reference

BEHAVIORAL RISK FACTOR SURVEILLANCE AND EPIDEMIOLOGY

Jean Sheridan
Epidemiologist

COMMISSIONER

DEPUTY COMMISSIONER OF HEALTH AND MEDICAL SERVICES

BUREAU OF HEALTH

DIRECTOR ASSISTANT DIRECTOR

OFFICE MANAGER

Division of Maternal and Child Health	Division of Public Health Nursing	Public Health Laboratory	Division of Health Engineering	Division of Health Promotion and Education	Division of Disease Control	Office Of Dental Health
Adolescent Prevention Pro.	Health Station	Chemistry	Drinking Water	Community Chronic	Epidemiology	Adv. Council
Family Planning	Regional Operations	Toxicology	Plumbing Control	Disease Prevention	TB Control	Eval. Consult.
Genetics	Abuse/Neglect	Implied Consent	Health & Safety	Community Health	STD Program	Dental Consult
Newborn Screen.	Communicable Diseases	Radiation	Sanitation &	Promotion Program	Immunization	Theatre Arts
Prenatal	Death/Childhood SIDS	Pesticides	Inspection	Community High	Program	Consult.
Children's Lic.	Head Start	Drug Analysis	Board of Cert.	Blood Pressure	Environmental	P.H. Hygiens.
Accident Prev.	Lead Poisoning	Water Lab	for Water Plant	Program	Health Unit	Regional
Treatment Progs.	Maternity/Paternity	Organics	Operators	Diabetes Control	Tumor Registry	Health Ed.
Crippled Childrens	Newborn/High Risk	Inorganics		Project	AIDS Program	Consults
Medical Eye	Preschool Children	Bacteriology		Behavioral Risk		
	Clinics	Clinical Micro.		Factor Surveillance		
	School Health Svcs.	Mycobacteriology		Smoking Prevention &		
	Tuberculosis Control	Parasitology		Control Activities		
	Refugee Program	Mycology		Dept. of Human		
	Adult Health Program	Virology		Services Library		
		Serology				
		Rabies Testing				

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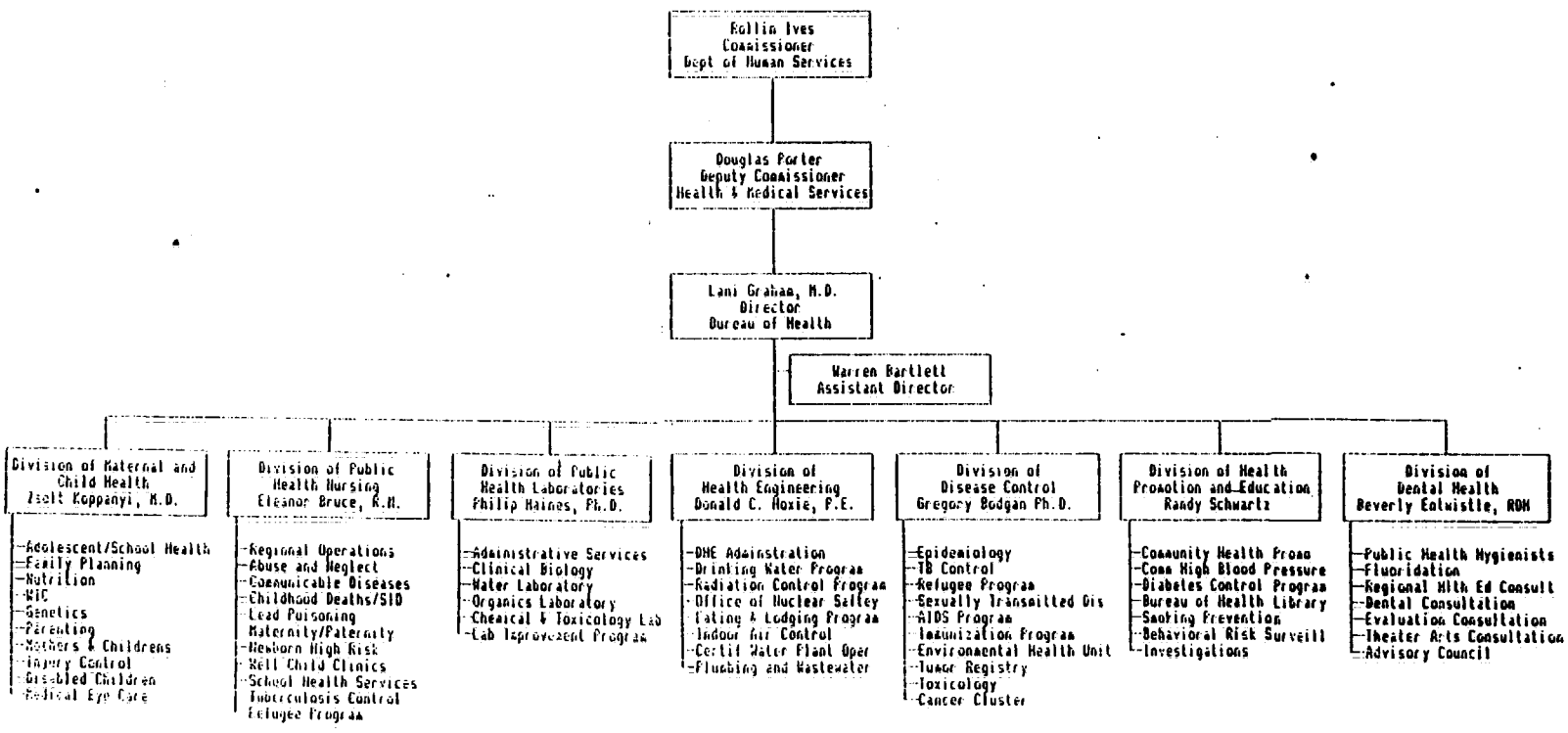
BUREAU OF HEALTH
ORGANIZATIONAL CHART



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7.2 Public Health and Health Promotion Intervention Experience

The Maine Bureau of Health has a demonstrated capacity to develop, implement and evaluate public health and health promotion community interventions including local and statewide programs.

Many of these public health interventions have been implemented through cooperative agreements or grants with federal agencies such as the Centers for Disease Control, National Cancer Institute, and National Heart, Lung and Blood Institute. A number of public health programs have been established and institutionalized through state general funds. In addition, the Bureau of Health has a commitment to addressing chronic disease prevention and control as a public health problem in collaboration with other sectors of government as well as with professional organizations and private sector interests.

The Bureau has excellent experience in leading and participating in coalitions, councils, network and consortia designed to link organizations to accomplish public health goals in Maine.

7.2.1 Intervention Projects - Division of Health Promotion and Education

7.2.1.1 Maine Diabetes Control Project

In 1977, Maine became one of the states initially awarded a contract by the Centers for Disease Control (CDC) for a state-based diabetes control program to plan, develop and implement activities designed to reduce the morbidity, mortality and economic costs of diabetes and its complications. In 1980, Maine received funds under a cooperative agreement with CDC to continue these activities and in 1986 and 1990 was again awarded a cooperative agreement for state-based diabetes control program. Activities of the Maine Diabetes Control Project (DCP) include patient and professional education programs and development of programs designed to promote changes in the health care delivery system. The Maine DCP is nationally recognized for its pioneering efforts in achieving third party coverage for diabetes outpatient education, a health systems change that has institutionalized diabetes patient education in virtually all hospitals in Maine. Nationally, this has become a widely accepted reimbursement procedure based in large part on the work done in Maine. The pilot study which resulted in reimbursement was first reported in the CDC publication, Morbidity and Mortality Weekly Report (MMWR). In 1986, the Maine DCP received the Secretary of Health and Human Services' Community Health Promotion Award for the Ambulatory Diabetes Education and Follow-Up (ADEF) Program.

A complication specific intervention of the Maine DCP, The Diabetes in Pregnancy Project has begun to receive national attention and demonstrate effectiveness. Utilizing a combination of patient education, professional organization and community organization of health professionals, the DCP has implemented a professional resource network on diabetes in pregnancy and is currently engaged in a prospective study of pregnancy outcomes. This project was highlighted in the November 20, 1987 issue of Morbidity and Mortality Weekly Reports.

In 1987, the Maine Legislative provided funding for two positions of the DCP previously funded through the CDC Cooperative Agreement.

7.2.1.2 Community Chronic Disease Prevention

Maine is one of only four states to have received a cooperative agreement to implement a community-based chronic disease prevention program focused on risk factors for heart disease and cancer. The Community Health Promotion Program is working with three communities: Mount Desert Island (MDI), the Portland West End Neighborhood and the Penobscot Indian Reservation (Indian Island). The three year cooperative agreement began October 1, 1987. All three communities have hired project coordinators (1/2 FTE), collected baseline data on behaviors, knowledge and program participation concerning heart disease and cancer risk factors, and initiated interventions on smoking, exercise, and nutrition. The third and final year of the project has focused on continuing the intervention activity and on evaluation.

Interventions specific to tobacco use have centered on training of community people and local coordinators to conduct smoking cessation classes, worksite smoking policy development and public education. Most notably, the Penobscots have used data from their Behavioral Risk Factor Survey showing a 54% smoking prevalence on the Island and compared that with other Native American prevalence rates and the general Maine population. In addition, they conducted additional surveys of youth (K-8), seniors and employees of the Health and Human Services Building staff. Using these data and information about health risks especially to children, they have been able to marshall public support for a smoking ban in their Health and Human Services building (the center for a number of activities on the Island ranging from day care to senior lunches). This policy went into effect July 1, 1990 with little public resistance.

The Portland project has successfully established two smokers' anonymous support groups. They have also instituted policies banning smoking at Portland West Neighborhood Council Meetings and in their offices. The Council is comprised of low income representatives of the community. It should be noted that these policies were developed in partnership with community people and voted on at council meetings.

The MDI project has provided self help quit kits as well as conducted smoking cessation classes. The coordinator is currently working with the Island's largest employer, Jackson Lab, to implement their smoke free worksite policy.

7.2.1.3 PATCH (Planned Approach to Community Health)

A process designed by the Centers for Disease Control to facilitate an organized approach to community health promotion is named PATCH (Planned Approach to Community Health). In May, 1986 the State of Maine, Division of Health Promotion and Education was selected as one of the then nine states to work with CDC in the delivery of this PATCH process throughout the state. PATCH provides a forum through which health education professionals and citizens plan, conduct and evaluate health promotion programs at the community level. Working as a team, representatives from the Bureau of Health's Division of Health Promotion and Education, local health agencies, community workers, citizens and staff from the Centers for Disease Control form an active partnership to implement health promotion programs designed to meet the priority health needs of a community and reduce the leading causes of death.

Currently, there are five active PATCH communities in Maine: BLISS (Baldwin, Limington, Sebago and Standish) in southern Maine; Mt. Desert Island, Waterville and Ellsworth in central and eastern Maine; and the St. John Valley in northern Maine. Three of the sites have identified priority risk factors and begun interventions to address these risk factors.

BLISS selected sedentary lifestyle and has established walking clubs in each of the four communities comprising their PATCH site. In fact, they have been asked by a neighboring community to help start clubs in their area. MDI has selected high blood cholesterol, sedentary lifestyle, and smoking as priority risk factors. This site is also a CCDP site and has been discussed in that section. Greater Waterville has selected breast and cervical cancer detection as their priority area. They have designed intervention concerning physicians and office staff awareness as well as developed and broadcast PSA's for community awareness. This year, they are planning interventions for their second priority - tobacco use. CDC has provided some seed money to establish a resource section on smoking cessation in both the

high school and town library for each of the towns comprising this PATCH site. The St. John Valley and Ellsworth have recently completed Behavioral Risk Factor Surveys and will identify priority health problems this year.

7.2.1.4 Community Cardiovascular Risk Reduction Program

Since 1977, the Maine Bureau of Health has coordinated the Community High Blood Pressure Program (CHBPP) to conduct high blood pressure screening, detection and referral activities. Under the CHBPP, the Bureau of Health has subcontracted with community health agencies to screen approximately 35,000 individuals annually. In 1990, the CHBPP was changed to Community Cardiovascular Risk Reduction Program (CCRRP), with the program goal to reduce the burden of cardiovascular disease (CVD) on the community. The focus of activities conducted by the CCRRP sites are the three CVD risk factors most amenable to reduction, and for which the strongest scientific evidence of efficacy of control exists: high blood pressure, elevated blood cholesterol and tobacco use. In addition, the program encourages local sites to address secondary risk factors such as weight control, reduction of sedentary lifestyle, and diabetes control.

In 1980, Maine became one of seven states participating in the National Heart, Lung, and Blood Institute's (NHLBI) Hypertension Control Program (HCP). The goal of Maine's HCP was to establish a statewide model that demonstrates improvement in hypertension control as a result of the development of a cooperative management system to coordinate the use of scarce hypertension control resources in the rural state of Maine. The NHLBI contract enabled the development of resources for hypertension control in Maine, and funded household surveys to determine the awareness and prevalence of hypertension, and surveyed providers and health service delivery organizations to determine care patterns.

In 1989, the Maine State Legislature passed cardiovascular risk reduction legislation "An Act to Establish a Statewide Program of Community-based Heart Attack and Stroke Prevention Programs" which included an annual appropriation of $100,000. The legislation directed the Bureau of Health, Division of Health Promotion and Education to develop heart attack and stroke prevention programs in communities and regions throughout the State. The community programs shall:

(1) provide public education to schools, community groups and workplaces about cardiovascular risks;

(2) provide blood pressure and cholesterol screening, referral and follow-up to the general public and workforce populations; and

(3) provide smoking cessation programs for community members wishing to quit.

The Division intends to fund community intervention sites to implement the items above as well as develop a statewide CVD risk reduction campaign to provide overall support for the community interventions.

7.2.1.5 Institute and Workshops

The Division of Health Promotion and Education has developed and implemented a series of professional education and citizen training workshops over the past several years. In 1986, the Division sponsored a full day workshop on Individual and Community Health Behavior Change for worksite health promotion coordinators and patient education staff of the Diabetes Control Project's ADEF sites. Donald Iverson, PhD (at that time, Associate Director of the Cancer Control Sciences Program at NCI) was the presenter.

In 1987, the Division began the Community Health Promotion Institute, an annual workshop for community health workers and citizens involved in the PATCH and CCDP sites. The first Institute, the "PATCH Institute" featured Thomas Lasater, PhD of the Pawtucket Heart Health Program, (presenting Community Approaches to Health Promotion), Marshall Kreuter, PhD of the Centers for Disease Control (presenting on the National PATCH program), and a series of small workshops. The second Institute in 1988 again featured Dr. Kreuter. Also on the agenda were a panel on coalition building and community action, a session on program institutionalization (by Robert Goodman, PhD, MPH and Allan Steckler, DrPH) and workshops on media, volunteers and other topics.

Because of the success and perceived value of past Institutes, the 1989 Community Health Promotion Institute was opened to all public health workers and interested parties in Maine. The theme of the workshop was "Individual and Community Health Behavior Change: What Works." Plenary sessions included "Community Based Research for Health Promotion: Applying What We've Learned" by Maurice Mittelmark, PhD of Bowman Gray School of Medicine formerly of the Minnesota Heart Health Program; "The Year 2000 Objectives for the Nation: Implications for State and Local Health Planning" by Martha Katz, MPA, Director, Office of Planning and Evaluation, Centers for Disease Control. Workshops included: "Making Health Communications Programs Work" by Rose Mary Romano, US Office on Smoking and Health; "Cancer Prevention: Program Ideas and Resources," by Jeffrey McKenna, Office of Cancer Communications, NCI; "Implementing Policy Changes in Organizations" (using smoking policy as a model), by Edward Miller, Executive Director, American Lung Association of Maine; and "Ethical Considerations and Health Behavior Change," by Daniel Merrigan, Boston University School of Public Health. Over 150 people attended the 1989 Institute.

Due to the success of the first three Institutes, the Division of Health Promotion and Education was asked by the Maine School Health Education Coalition and the Maine Adolescent Pregnancy Coalition to hold a joint conference. The Institute will be held in December 1990. The theme will be "Grassroots Organizing: A Skills Building Conference for Volunteers and Health Professionals."

The Division of Health Promotion and Education also provided a series of one-day professional development workshops for Bureau of Health staff and other public health professionals in Maine . The series included:

- Chronic Disease Epidemiology
  Jane McCusker, MD - University of Massachusetts

- Cancer Epidemiology
  Harry Pastides, PhD, University of Massachusetts

- Practical Evaluation Methods for Health Promotion Programs: A Qualitative Approach
  Robert Goodman, PhD, MPH, University of North Carolina

- Cardiovascular Disease: Epidemiologic and Preventive Aspects
  Robert Goldberg, PhD, University of Massachusetts Medical School

- Promoting Health - What Works? Marketing Disease Prevention: Strategies for Public Health
  R. Craig Lefebvre, PhD, Pawtucket Heart Health Program

- Exercise Adherence: Problems and Prospects for Health Promotion and Physical Fitness
  Rod Dishman, PhD, University of Georgia, Athens

- Policy Approaches to Tobacco Prevention and Control
  staff of the Institute for Smoking Behavior and Policy, Harvard University

Over fifty (50) health professionals attended each workshop.